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ABSTRACT

There is strong evidence of the inadequacy of existing therapeutic modalities for Spanish speaking clients. Intended to bring together new information on the psychotherapeutic approaches, techniques, and goals appropriate to the Spanish speaking, this monograph contains seven articles which attempt to study the multiplicity of variables involved in the development of effective mental health services to the Spanish speaking. Focusing on the process involved in developing specific therapeutic techniques demonstrating their possible usefulness in working with the Spanish speaking, the articles discuss: mental health service utilization by Mexican Americans; mental health services in East Los Angeles--an urban community case study; Mexican American dropouts in psychotherapy as related to level of acculturation; psychotherapist ethnicity and expertise as determinants of self-disclosure; applicability of a behavioral model in serving the mental health needs of the Mexican American; assertive training with low income Mexican American women; and behaviorally oriented group therapy--a successful application in the treatment of low income Spanish speaking clients. (NQ)

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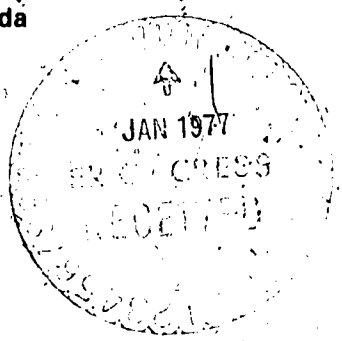
PSYCHOTHERAPY WITH THE SPANISH-SPEAKING: ISSUES IN RESEARCH AND SERVICE DELIVERY

Edited by

Manuel R. Miranda



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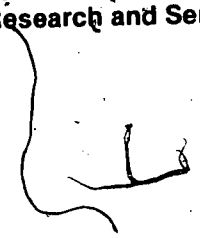

PREFACE

The current monograph was developed to fulfill a specific need in the area of psychotherapy and behavior change. While mental health specialists have become increasingly aware of the psychological adjustment problems of the Spanish speaking population in this society, they have also recognized and documented the inadequacy of mental health services available to this population. The variety of attempts to employ traditional therapeutic techniques with the Spanish-speaking client has yielded discouragingly low success outcomes and alarmingly high dropout rates. The lack of knowledge and skill necessary to engage the Spanish-speaking in treatment has further contributed to their dilemma. The fact that a significantly high percentage of the Spanish-speaking population continue to exhibit massive psychological problems (e.g. drug and alcohol abuse, family disruption, legal prosecution) and inspite of advances in mental health services there is strong evidence of the inadequacy of existing therapeutic modalities for such clients. It is the intent of this monograph to bring together new information on the psychotherapeutic approaches, techniques, and goals appropriate to the Spanish-speaking.

The range of articles in this monograph attest to the increasing development of interest in the psychotherapeutic process among Latino scholars. All of the articles attempt to study the multiplicity of variables involved in the development of effective mental health services to the Spanish-speaking. Starting with the accumulation of data describing perceptions held by the Spanish-speaking toward existing mental health systems (Padilla and co-workers; Moll, Rueda and associates) and continuing with the analysis of personality and cultural characteristics potentially affecting the development of a positive therapeutic relationship (Miranda and co-workers; Acosta and Sheehan), the monograph focuses on the process involved in developing specific therapeutic techniques demonstrating their possible usefulness in working with the Spanish-speaking (Casas; Boulette; Herrera and Sanchez).

The various authors of these articles strongly suggest that treatment approaches for the Spanish-speaking client should be based not only on more service, but on more appropriate service. Basic revisions of traditional forms of psychotherapy are needed if mental health services in the Latino community are to become maximally effective. The widely prevalent notion that psychotherapy is not the treatment of choice for the low-income Spanish-speaking client is directly questioned. As reflected in the discussion sections of these seven articles, the failure of

psychotherapy with low income Spanish-Speaking clients may be in large measure due to the insistence on a particular model of treatment, as opposed to personality and/or cultural factors of the Spanish-speaking.

In many ways, the work reviewed in this monograph reflects a definite maturation in the development of Latino mental health. Not only is a demand for empirical verification of the therapist's effectiveness in his work with the Spanish-speaking called for, but a more sophisticated awareness of the problems involved in such an undertaking is demonstrated. Recasting an observation made by Bergin and Garfield,[1] in reference to psychotherapy research, the study of psychotherapy and the Spanish-speaking appears to have moved beyond the stage of asking the simplistic question, "Is psychotherapy effective?" More encouragingly, Latino researchers are beginning to prepare themselves to respond to the question, "Under what conditions will this Spanish-speaking client with these particular problems, be changed in what ways, by which specific types of therapists?"

The seven articles appearing in this monograph were initially prepared for presentation at two separate sessions at the Western Psychological Association Convention held in Los Angeles, California, April 10-13, 1976. Both sessions dealt with mental health issues in the Spanish-speaking community. Amado Padilla and Frank Acosta (Co-authors of articles in this monograph) were primarily responsible for organization of the two sessions and served as chairmen during the presentation of the papers.

A very special note of appreciation must be expressed to Teresa Aguilar for her highly competent secretarial skills and patient acceptance of the numerous manuscript revisions required. Although having been with the Center only very briefly, her contributions have been considerable. Victor B. Nelson Cisneros provided experienced and thoughtful assistance to the editorial preparation of the manuscripts. His professional dedication to the task is especially acknowledged.

This volume is published as Monograph Number Three by the Spanish Speaking Mental Health Research Center, Amado Padilla, Principal Investigator, University of California, Los Angeles, California 90024, in the interest of achieving the broadest distribution of the ideas and recommendations contained therein. Copies may be obtained at a nominal charge from the principal investigator. The Spanish Speaking Mental

[1]Bergin, A. E. and Garfield, S. L. *Handbook of Psychotherapy and Behavior Change: An Empirical Analysis*. New York: Wiley and Sons, Inc., 1971.

Health Research Center supports a number of research and publication projects on the social-class correlates of Latino community mental health with potential relevance to public policy formation. The SSMHRC Program is funded by USPHS Grant 5-ROI-MH24854 from the Center for Minority Mental Health Programs, Dr. James Ralph, chief; National Institute of Mental Health, United States Department of Health, Education and Welfare.

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TABLE OF CONTENTS

7

p 6 blank

MENTAL HEALTH SERVICE UTILIZATION BY MEXICAN AMERICANS

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It is well known that mental health facilities are underutilized by Mexican Americans (Padilla and Ruiz 1973; Padilla, Ruiz and Alvarez 1975; Karno and Edgerton 1969). Alternative explanations for this lower rate of use have concentrated on the following: (1) discouraging mental health facility policies, such as language barriers and class and cultural disparity between client and therapist, (2) utilization of folk medicine and *curanderas* instead of conventional support in times of stress.[1] Data will be presented in this paper from a stratified sample of Mexican Americans in three Southern California towns comparing the relative importance of each of these explanations of lower mental health clinic usage.[2]

The sample was taken equally from nine census tracts in all: three census tracts of varying degrees of ethnic density in each town. Spanish-surname households were contacted door-to-door by bilingual interviewers in the spring and summer of 1975. Of those households with Mexican American residents, 77% accepted the interview giving a total of 666 respondents. About an equal number of Spanish and English language questionnaires were administered. All of the data presented in this paper are descriptive in nature; no analysis of statistical significance is reported.

Description of the Sample

In both age and marital status, the sample is very much like the urban Spanish-speaking/surname (SS/S) population in California as a

[1]See Padilla and Ruiz (1973) and Padilla et al. (1975) for further description of these two alternative explanations. While it is agreed there is considerable diversity within the population of Mexican descent, there is still a need for a term to encompass the ethnic group as a whole; we shall use the term Mexican American for this purpose.

[2]This study was made possible by the National Institute of Mental Health, Grant number MH26099-01 and -02.

p. 8 blank

whole.[3] The majority of the respondents are married (84%) and between the age of 35 and 59; another 37% are less than 35 years old and 14% are 60 years of age or more. Due to sampling problems, more of the respondents are women (76%) than are found in the general population but very few differences by sex appear in the data and these are noted where they occur.

There is an average of 4.5 persons per household. Only 16% of the households have more than six members. Almost all of the respondents (93%) have children and most of these (86%) still have children living at home. The average family has one to three children, but families with five or more children (33%) are not uncommon. Very few households (4%) have unrelated people, such as friends, roommates, or boarders, living in the home.

The nuclear family is the most common type of household pattern. The household composition of respondents in this survey is very much like that found by Grebler, Moore and Guzman (1970) in Los Angeles and San Antonio with one notable exception; while extended families make up only 3-5% of the households in the study by Grebler *et al.*, 11% of the households in this survey are extended (see Table 1). About 4% of the households are joint households, most of them made up of related nuclear families.[4]

The extended kinship group continues to be a strong institution among the Mexican Americans surveyed. About 90% of the respondents have relatives or in-laws living in town and 56% of these are related to more than five households. The great majority of respondents with relatives in town see some of their kinsmen at least once a week; almost half visit with relatives daily. Dependence on the family as a source of instrumental support is fairly common. About three quarters of the respondents report helping a relative in the past year in such capacities as loaning money, babysitting, home repairs, and so on. The receipt of aid from family members is reported by 65% of the sample.

Compadrazgo, or the custom of choosing godparents for children who participate in the rituals of the Catholic church, also remains a

[3]Fully 91% of the SS/S population in California is urban. Of these, 75% are married and the age category proportions are as follows: (1) 44% are less than 35 years old, (2) 44% are 35 to 59 years of age, and (3) 12% are over 59 years old. About 51% of the urban SS/S are women (U.S. Bureau of Census 1973).

[4]A joint household is one in which two or more nuclear families are present. The families may or may not be related. Therefore, this kind of household overlaps to a large extent with the extended type of household in this sample.

viable institution among Mexican Americans. Traditionally considered an extension of the kinship system, *compadres* take on rights and obligations which are more like those of relatives than friends. Respondents tend to be Catholic (88%) although 10% are protestants, primarily members of evangelical sects such as Jehovah's Witnesses. Even the protestants, however, tend to have *compadres*, perhaps vestiges of earlier membership in the Catholic church. About 88% of the respondents have *compadres* and most of these (80%) have *compadres* living in town.

TABLE 1

Household Composition

	Number	%
Nuclear family households		
Husband, wife, and children	401	60
Husband, wife, no children	61	9
Single parent households		
Wife and children	54	8
Husband and children	12	2
Extended family households[a]	74	11
Single person households[b]	35	5
Others	29	4
Total	666	100

[a]An extended family household is defined here as a nuclear family household with other relatives present.

[b]A single person household is one in which the respondent is alone or is unrelated to others living in the household.

Thus, most Mexican Americans have either real or fictive (*compadres*) kin living nearby. In fact, the majority (70%) have both relatives and *compadres* living in town; only 3% have neither.

With respect to language and birthplace, there is little uniformity within the sample. Forty-two percent of the respondents were born in Mexico. Most of the others were born in California. While 42% of the sample speak mainly Spanish, 31% primarily speak English and 27% are bilingual.

As there are differences in language and cultural background, so are there differences in ethnic identification among the respondents. The majority of the sample identify as "Mexican" (54%). The second most common identity is "Mexican American" (27%). Only 7% take the label of "American of Mexican descent" and 6% prefer to be called

"Chicano". Most of the respondents who identify as "Mexicans" are from Mexico (69%) and speak mainly Spanish (67%). The other ethnic group names tend to be taken by respondents born in the United States. The respondents identifying as "Mexican Americans" are either bilingual (41%) or speak mainly English (40%), while both the "Americans of Mexican descent" (63%) and the "Chicanos" (53%) are primarily English-speaking.

Like the urban SS/S California population as a whole, the respondents are largely non-transients with less than 12 years of education who are from blue collar families.[1] Most of the respondents (89%) have lived in their community for over five years; one out of five is a native of the city in which they presently live. The median years of education for respondents is nine years; 69% have not completed high school. Eighty-five percent of the heads of household sampled have blue collar jobs and the majority of these are semi-skilled and unskilled occupations, including operatives, service workers, and laborers. Fifteen percent of the heads of household are farmworkers.

The samples taken from the three towns are fairly consistent with regard to the above characteristics, with the exception that one of the cities has a larger proportion of respondents who speak mainly English. This is probably due to the relative absence of factory and laborer jobs in the vicinity of this city which results in fewer Spanish speaking only immigrants being attracted to this city.

Those respondents born in Mexico constitute a distinct segment of the ethnic population compared to those born in the United States. The majority of those born in Mexico took the Spanish questionnaire (87%), identify as "Mexican" (88%), have less than eight years of education (69%), and have lived in their community for 15 years or less (65%). In contrast, most of those born in the United States took the questionnaire in English (81%), identify as something other than "Mexican" (70%), have more than eight years of schooling (84%), and have lived in their town for more than 15 years (77%). While only 15% of those born in Mexico have white collar or skilled blue collar jobs, 40% of the U.S. born are so employed. In other words, there are two segments within the population of Mexican descent which differ both culturally and socio-economically and which we will hereafter label as the immigrant and native groups.

[1]For the urban SS/S population of California, 76% have lived in the same county for five years or more, 61% of the population who are at least 20 years old do not have a high school education, and 78% of the male labor force over 19 years of age have blue collar jobs (U.S. Bureau of the Census 1973).

The respondents born in the United States are further differentiated by generation: 38% of the sample is second generation with one or both parents born in Mexico and 20% is third generation with both parents born in the United States. The language and educational differences noted above are also marked between these two generations. In the third generation, 63% speak mainly English and 50% have graduated from high school while only 42% of the second generation respondents speak mainly English and 38% are high school graduates. The youthful age of the third generation sample probably has much to do with these variations; 58% are under thirty five years of age compared to 27% in the second generation.

Knowledge and Use of the Public Mental Health Clinics

Knowledge of the public mental health clinics in the community appears to be widespread. About 48% of the respondents know about their neighborhood clinic; one out of five could give the correct location of a mental health facility when asked.

Knowledge of mental services is affected by most of the previously discussed indicators. Language and birthplace are of great importance. About 55% of those taking the English questionnaire could identify the local mental health clinic while only 40% of those taking the Spanish questionnaire could do so. In addition, far more second (51%) and third (64%) generation Mexican Americans know about the clinic than those respondents born in Mexico (37%).

Knowledge of the local mental health clinic is also affected by age and sex. More women (51%) know about the clinic than men (36%), and respondents under the age of thirty-five (58%) are more knowledgeable than older respondents (42%).

Finally, as we might expect, socio-economic status and length of residence in town are positively associated with knowledge of the mental health agency. Those respondents who have lived in the community more than five years are more likely to be able to identify the clinic (49%) than are the more transient respondents (37%). Furthermore the respondents with at least eight years of education (58%) and who are from white collar and skilled blue collar households (56%) are more likely to know about the clinic than are respondents without eight years of schooling (32%) and those from semi-skilled and unskilled blue collar families (45%). It is important to note that there is no significant increase in knowledge about the mental health clinic with an increase in education beyond eight years; those respondents with some college (55%) are as likely to know of the clinic as are those with eight to eleven years of school (56%).

With due consideration given the differences between the segments of the Mexican American population, it remains true that at least one out of three respondents in each segment is cognizant of the public mental health facilities. Information about the presence of the clinics does not appear to be lacking although this does not indicate the extent of knowledge about the kind of services offered. Fewer respondents probably are aware of what the services entail. Nevertheless, the respondents are fairly well informed about the location of their local mental health clinic.

Even more respondents (60%) indicate willingness to use the mental health facilities. Of those who say they are unwilling, most prefer alternative kinds of help for emotional problems, especially their family doctor. Very few (4%) are unwilling because they believe the clinic services are not worthwhile.

Differences are evident between the two segments of the Mexican population, the immigrants and the natives, in attitude toward mental health services. More people born in Mexico are willing to use a mental health facility (69%) than are the U.S. born (53%). Similarly, more respondents who speak Spanish (71%), identify as "Mexican" (64%), and have less than eight years of schooling (70%) are likely to approve of using a clinic than those respondents who speak English (50%), identify as "Mexican American," "American of Mexican descent," or "Chicano" (54%), and have at least eight years of education (54%). Furthermore, more respondents from semiskilled and unskilled blue collar households (64%) tend to be willing to go to a clinic than those from white collar and skilled blue collar (53%) families. As with knowledge about the location of the clinic, the immigrant and native segments of the Mexican population differ in attitude toward use of the mental health agency. The immigrants are less likely to know about the clinic but more likely to be willing to utilize the services offered than are the natives. While these differences are present, both segments of the Mexican population are fairly knowledgeable about the mental health facility's location and the majority of both segments appear willing to make use of a clinic.

Actual use of mental health services is much less prevalent and there appears to be little difference in usage by the native and immigrant households. Only 10% of the households surveyed have ever actually used a mental health clinic; no more than 2% of all respondents used the agency themselves in the last two years. There is no indication of the extent of utilization by these respondents or members of their households, but both the households with Spanish-speaking immigrant respondents

who have little education and the households with more-educated native respondents who speak English seem to contribute clients to mental health facilities at about the same rate (between 7% and 12%).

The data on respondents who have gone to a mental health clinic themselves can only be suggestive because of the small number of users (N = 16). Nevertheless, it appears that Mexican Americans who use mental health clinics are not typical of either the native or immigrant population. Seventy-five percent of those using the mental health clinic in the last two years were born in the United States. Contrary to expectation, however, the majority (63%) of them identify as "Mexican." In addition, most of the recent users report speaking mainly Spanish (33%) or being bilingual (40%) and yet only 31% took the questionnaire in Spanish. Thus, while their identity and reported language ability are more like the immigrant population, their actual language usage is more in accord with the native population. In occupation and education, the users resemble the natives more than the immigrants, but here again there are differences which set the users apart. While the users and native populations come from similar occupational levels, the users are not as highly educated. Forty-two percent of the native segment have graduated from high school compared to 19% of the users. In sum, respondents who have used the mental health clinic appear not to be representative of either the immigrant or native segment of the Mexican population, and perhaps it is this lack of clear identity which contributes to their emotional problems.

Those respondents who have had some contact with the local mental health facility, or know a friend or relative who has (N = 90), tend to have a good opinion of the services offered. Although 19% believe there is a language problem for Spanish-speaking clients at the clinic, only 6% believe the clinic staff is hard to talk to in other respects. Moreover, the majority (58%) believe the clinic is successful in its treatments. Roughly the same attitudes are held by those few respondents who have used a mental health facility themselves. In other words, the quality of the services offered by mental health clinics does not appear to be discouraging potential Mexican American clients.

Alternative Mental Health Resources

More important in explaining the low use of mental health facilities by Mexican Americans is their preference for other sources of help in times of emotional stress. In response to a general question asking for the first place a Mexican American who has an emotional problem should go for help, the most common replies include a physician, a relative or

compadre, or a priest/minister (see Table 2). Taken together, the family doctor and a relative/*compadre* are mentioned by almost half of the native and immigrant populations alike.

TABLE 2

First Place Recommended for a Person with an Emotional Problem

	Number	%
Doctor	(159)	25
Relative/*compadre*	(132)	20
Priest/minister	(107)	17
Friend	(89)	14
Mental Health Clinic	(88)	14
Psychiatrist/counselor	(61)	9
Mexican American community worker	(8)	1
Curandero	(0)	0
Other	(6)	1
Total	(650)	100

When asked about specific emotional problems, including depression, anxiety, bewitchment, suicidal tendencies, alcoholism and drug addiction, recommendations about sources of help vary considerably (see Table 3). For problems of depression and anxiety, the family doctor is mentioned by the majority of respondents. Of the six emotional problems, only for depression is a relative/*compadre* suggested with any frequency and then only by a small number of respondents (10%).

Contrary to evidence provided by other authors (Creson, McKinley and Evans, 1969; Torrey 1973), curanderos, or folk healers, do not appear to be relied upon with any frequency. They are never recommended by respondents as the first place to go for help with an emotional problem.

When asked specifically about the problem of bewitchment, most respondents replied that they do not believe in it. Over a third of the respondents, when prompted further, advise talking with a priest or minister, while a *curandero* is recommended by 17% of the respondents. Bewitchment is the only specific problem for which respondents mention *curanderos*. The tendency to advise seeing a *curandero* is, as expected, found more among the immigrant than the native population. Respondents born in Mexico are about as likely to recommend seeing a *curandero* (24%) as a priest (29%) for bewitchment. U.S. born English-speaking respondents, on the other hand, favor seeing a priest (42%)

TABLE 3

Recommended Sources of Help for People with Emotional Problems

	Anxiety	Depression	Suicide	Bewitchment	Alcoholism	Drug Addiction
Doctor	62%	61%	11%	16%	21%	32%
Priest/ Minister	6	4	19	36	3	2
Relative/ *compadre*	5	10	5	1	2	2
Friend	4	8	6	2	1	1
Psychiatrist	9	8	24	12	2	2
Curandero	0	0	0	17	0	0
Mental clinic	6	4	7	2	2	4
Police	1	0	16	0	1	4
Alcoholics Anonymous	0	0	0	0	57	0
Drug Abuse clinic	0	0	0	0	0	32
Other	6	5	12	16	11	21
Total	100	100	100	100	100	100

rather than a *curandero* (11%). It is only within the immigrant group, thus, that the belief in the effectiveness of curanderos is retained, and even within this group, folk healing is recommended by a minority of respondents.

A suicide attempt is most commonly felt to be an emotional problem best dealt with by a psychiatrist/counselor or a mental health clinic. Yet a very large proportion of immigrants (27%) believe the police should be called in first. Respondents born in the United States are somewhat more likely to recommend a psychiatrist/counselor (30%) than immigrants (20%).

For the most part, respondents feel alcoholism and drug addiction require specialized treatment. The source of help for alcoholism most frequently suggested by both natives and immigrants is Alcoholics Anonymous. Drug addicts are advised to go either to a doctor or a drug abuse clinic. Natives are more likely to recommend a drug clinic while immigrants tend to suggest seeing a physician.

While the mental health clinic is recommended by 14% of the respondents as the first place a person should go for an emotional problem in general, very few respondents suggest the clinic as a source of help for the six specific problems discussed above. Other alternatives are preferred in these hypothetical situations. The same kind of preferences

are maintained in actual practice. The most common sources of help for respondents who admit having an emotional problem in the last year are a relative/*compadre*, friend, doctor, and a priest/minister (Table 4). English-speaking respondents tend to seek help more frequently than Spanish-speaking respondents from the first three of these four resources. Curanderos were consulted by only 2% of the respondents, confirming the previous finding that this indigenous resource is not important for Mexican Americans in these three towns.

TABLE 4

Mental Health Resources Used by Respondents in a One Year Period Prior to Interview*

	Number	%
Relative/*compadre*	241	36
Friend	170	26
Doctor	140	21
Priest/minister	106	16
Mexican American community worker	57	9
Group meeting	46	7
Private psychiatrist/counselor	25	4
Mental Health clinic (2 year period)	16	2
Social agency	15	2
Curandero	11	2
Other	40	6

*Note: Percentages add up to more than 100% because respondents may have used more than one mental health resource.

Furthermore, when taken as a whole, alternative mental health resources are more likely to be utilized by natives than by the immigrant segment. More respondents who speak English (65%) have used one of the mental health resources listed in Table 4 than have the Spanish-speaking respondents (50%); the same is true for respondents born in the U.S. (62%) versus those born in Mexico (51%), respondents with more than eight years of education (62%) versus those with less (52%), and respondents from white collar or skilled blue collar households (66%) versus respondents from semi-skilled and unskilled families (55%). We must conclude that either the immigrants have fewer emotional problems or have less access to sources of help. Considering that the immigrants are probably subject to greater emotional stress due to poverty, limited education, lack of fluency in English, and discrimination, it is more likely the lack of resources which accounts for the lower rate of use. This is

especially true with regard to the emotional support provided by relatives. Immigrant respondents are less likely to have many relatives living nearby than are natives, and immigrants are less likely to integrate in mutual aid practices with their nearby extended family. Bereft of the traditional cultural resources such as folk psychiatrists (*curanderos*) and an extended family support system and lacking access to public agencies, the immigrants are forced to go without proper mental health care. It is for this particular segment of the Mexican American population, therefore, that an expansion of alternatives for mental health treatment is most necessary.

Conclusion

Mexican Americans as a whole deal with emotional problems in a variety of ways. They tend to know about the neighborhood mental health clinics but these are not utilized to any great extent. Instead, Mexican Americans depend upon physicians, relatives, friends; and religious practitioners for treatment.

Clearly, mental health clinic usage is low among the Mexican Americans surveyed. This does not appear to be due primarily to lack of knowledge about neighborhood clinics or outright reluctance to make use of them. Almost half of the respondents know about the local clinic, and three out of five say they would be willing to contact a mental health facility. Furthermore, although the data is only suggestive, the majority of users believe the mental health clinics are successful in their treatments. In other words, there is no indication that respondents avoid the clinics because they hold negative attitudes about mental health services. Neither is the low clinic use due to the lack of need for mental health care, for more than half of the respondents replied they did require help with an emotional problem in the previous year. Lastly, the dependence upon *curanderos* is not extensive and cannot explain the low rate of clinic use by Mexican Americans.

The most significant reason for lack of use of mental health clinics is the preference for alternative resources when dealing with emotional problems. The most common resources relied upon are relatives, *compadres,* friends, physicians, and priests or ministers. Reliance on the extended family for support is the primary means of coping with emotional stress for Mexican Americans. Friends and *compadres* are extensions of this informal network of support. Doctors and priests tend to be utilized most often when emotional problems cannot be handled through relatives and friends. At this stage, doctors seem to be relied upon for problems such as anxiety and depression. Other problems, such

as bewitchment and suicidal tendencies, are most likely to be channeled into the care of priests and psychiatrists. The mental health clinic tends to be the last resort for those Mexican Americans who have tried many other methods of dealing with an emotional problem and been unsuccessful.

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MENTAL HEALTH SERVICES IN EAST LOS ANGELES: AN URBAN COMMUNITY CASE STUDY

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This is a case study of a mental health agency in the East Los Angeles (E.L.A.) community. The focus of this study was mental health services and the clientele of the E.L.A. Mental Health Services (ELAMHS). A major objective was to assess the mental health needs and resources in the E.L.A. community as perceived by both consumers (persons receiving a mental health service of ELAMHS) and providers (direct service staff of ELAMHS).

The research focused on 6 areas: (1) The demographic profile of the consumer study sample of E.L.A. Mental Health Service; (2) the consumers' and providers' perceptions of important factors in obtaining services; (3) awareness of alternate mental health systems, and perceptions of availability of services; (4) perceptions of the significance of language and ethnicity in service delivery; (5) consumer and provider perceptions of unmet mental health needs and community problems and (6) consumer and provider perceptions of causes of emotional problems.

Clearly, the consumers' perceptions about mental health service contributes to the extent that they will tend to utilize those services. Negative perceptions or perceptions that the service modalities are inappropriate to one's needs leads to low utilization rates, a phenomenon frequently reported among the SS/SS.[1]

[1] Although several terms have been used to describe the Hispanic population in other studies, such as Latino, Chicano, Spanish-surnamed, etc., the researchers

Obtaining the perceptions of those SS/SS consumers who have recently used a mental health facility provides significant information about what mental health means to this population and has direct implications for service delivery. Reliable identification of a consumers' perceived needs can greatly assist mental health agencies in providing effective services immediately as well as in the future.

Review of the Literature

In general, the cultural experience of the SS/SS is viewed as unique and judged important in the formulation and delivery of effective mental health services to this population (Padilla and Ruiz, 1973). This cultural experience is composed of a variety of life styles reflecting diverse needs which must be considered if the services are to be appropriate. Cultural variables such as those of language and identity are critical to the understanding of consumer needs. The influence of these cultural variables as suggested by the literature provided the basis for the data gathering framework of this study. Among those variables identified as important for inclusion were: educational level, language spoken, marital status of the respondent, and ethnicity. Definitions of important terms and concepts include the E.L.A. community, consumer (person receiving a mental health service), and provider (staff member of ELAMHS whose duties include provision of direct services). Perception was defined as "direct or intuitive cognition", and operationally measured by analysis of the responses given by consumers and providers in reference to mental health problems, needs and services.

Methodology

Setting

The E.L.A. Mental Health Service is a Short-Doyle funded community mental health agency providing direct and indirect outpatient services to E.L.A. and surrounding communities. Spanish-speaking individuals who live outside these boundaries but have no access to other mental health services are also served. In 1972, these centers served 840 individuals, of whom 80% were SS/SS, 15% were Anglo, 3% were Black, and 2% other. The staff is composed of four psychiatrists, two psychologists, one supervising psychiatric social worker, five psychiatric

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felt that the term "Spanish-speaking/Spanish-surnamed (hereafter SS/SS) was the most accurate and comprehensive. For additional discussion on this point see Padilla and Ruiz, (1973).

social workers, six community workers, three registered nurses with experience in mental health counseling, and two medical case workers.

Sampling Plan

Defining the provider as a member of the direct service staff of ELAMHS, the study design called for interviewing all the providers. Defining the consumer as a person receiving a mental health service at ELAMHS, the study design called for a 5% random sample of the total consumer population (N = 840) to be interviewed.

Initial contact with the selected consumer consisted of a letter written in both Spanish and English. The letter introduced the purpose of the study and identified the researchers as well as their institutional affiliations. The respondents were assured that anonymity would be maintained throughout the study.

Following the mailing of the letters, those consumers having a telephone were contacted for purposes of setting up interview appointments. Those consumers not having telephones were visited by the interviewers in order to complete interviewing arrangements. Only three consumers of the original 46 consumers selected for study were not interviewed. These interviews were not conducted because the consumer's psychiatric disorders made it impossible to obtain the necessary data. Thus, the final sample of consumers included 43 respondents.

Data Collection

Data collection was accomplished through the use of two structured interviewing schedules: one for the consumer, and one for the provider. Both schedules contained a mixture of open-ended and fixed alternative questions. An example of an open-ended question was, "What do you think are some of the causes of emotional problems (trastornos nerviosos)?" An example of a fixed-alternative question was, "If you were to receive services at the ELAMHS from a person who is of Mexican descent and who speaks Spanish; would it be a) more helpful to you; b) less helpful to you; or c) makes no difference to you."

The interview schedules were administered by the five authors of this study, all of whom are bilingual-bicultural. All five interviewers participated in interview training, which included learning interviewing techniques and recording responses, both in English and Spanish. To maintain uniformity, a standard introduction was given to each respondent prior to beginning the interview.

Data Analysis

The data were analyzed separately for each of the six areas of research interest. In investigating the importance of language and ethnicity in service delivery, Chi-Square tests were used to determine statistical significance.

Results

Demographic Profile of Consumers and Providers

The 43 consumers interviewed in this study represented a 5% random sample of the total active ELAMHS outpatient population (N = 840) at the time the study was undertaken. Of these consumers, 37 (86%) identified themselves as either Mexican American, Mexican born, or Latinos. Of the 22 providers interviewed, 17 (77%) identified themselves as either Mexican American, Mexican born, or Latino (see Table 1).

TABLE 1

Consumers and Providers Ethnic Identification

Ethnic Group	Consumer	Provider
Mexican American	25 (58%)	12 (55%)
Mexican born	9 (21%)	2 (9%)
Other Latin	3 (7%)	3 (14%)
Anglo	2 (5%)	3 (14%)
Asian	0	1 (4%)
Other	4 (9%)	1 (4%)

The largest number of consumers fell within the 31-40 year old range with the median age of the entire group slightly over 30 years of age. Providers' age ranged from 21 to 60, with the majority falling between 21 and 40 (see Table 2).

TABLE 2

Consumer and Provider Age Grouping

Age	Consumer	Provider
18-20	4 (10%)	0
21-30	10 (22%)	7 (32%)
31-40	13 (30%)	7 (32%)
41-50	12 (28%)	4 (18%)
51-60	4 (10%)	4 (18%)

Of the total consumer sample, over one-half (51%) indicated that they were not married, and 28 (65%) were identified as female. Although 13 consumers (31%) indicated that employment was their principal source of income, only nine of these consumers were employed full time (see Table 3). Of the consumer sample, 20 (48%) indicated having between a tenth and twelfth grade education. Another 6 (14%) indicated having at least one year of college (see Table 4). When asked which language they preferred to use when at ELAMHS, 20 (46%) responded English, while 15 (35%) preferred Spanish.

TABLE 3

Consumer's Principal Source of Income*

Source of Income	Consumer
Employment	13 (31%)
Welfare	14 (33%)
Relative	5 (12%)
Social Security	4 (10%)
Unemployment Benefits	0
Other	6 (14%)

*One consumer indicated no income.

TABLE 4

Consumer's Education Level

Highest Grade Completed	Consumer
1-3	1 (3%)
4-6	6 (14%)
7-9	9 (21%)
10-12	20 (48%)
13+	6 (14%)

Since other studies have reported difficulty in keeping the SS/SS in therapy, it was considered important to determine how long the consumers had been receiving services and how frequently they were seen at the clinic. Twenty-eight (65%) of the consumers had been receiving mental health services for more than nine weeks, with one-half of these having actually been in treatment for more than six months. Regarding frequency of service, 20 (46%) indicated having been seen on a weekly basis. The emergence of such a pattern would seem to indicate that services for this specific study population were relatively intense and long term.

Demographic data on the providers reflected that: they were equally divided according to sex (Males = 11, Females = 11); fields of training were concentrated in six areas as represented in Table 5; and 15 of the providers had previous work experience in an SS/SS community which was directly applicable to their present employment.

TABLE 5

Provider's Field of Training

Field of Training	Provider
Social Work	6 (27%)
Nursing	3 (14%)
Community Work	5 (22%)
Psychology	4 (18%)
Psychiatry	3 (14%)
Medical Case Work	1 (5%)

Although 19 (86%) of the providers indicated that they spoke Spanish fluently, only eight (36%) indicated that they used it more often than they did English while conducting therapy. This would appear to be consistent with the finding that only 35% of the consumers interviewed preferred to speak Spanish.

Consumer and Provider Perceptions of Important Factors In Obtaining Services

Two sets of variables emerged as significant in determining the consumers' path to ELAMHS: the first related to obstacles encountered that prevented the consumers from receiving services; and the second related to the referral patterns for the consumer.

As for the first set of variables, the problem or obstacle most often mentioned by the consumer was "lack of communication by the agency or lack of knowledge of available resources" (N = 14 or 32.6%). This category includes lack of publicity or community outreach by the agency, as well as a lack of knowledge by the consumer of the services that were available.

The second most frequently mentioned obstacle was lack of adequate "transportation" (N = 13 or 30.2%). This particular category includes lack of adequate public transportation and problems related to automobile transportation including cost and/or availability. The fact that ELAMHS serves a tri-catchment community which covers several incorporated and unincorporated areas extending over 44 square miles, provides an understandable explanation why 18 (42%) of the consumers had to travel over

five miles to receive services. Twenty-eight (65%) of the respondents indicated reliance on auto transportation, while only 14 (35%) indicated utilizing public transportation, primarily the bus. A third major obstacle mentioned by consumers was "stigma" or fear of being labeled crazy or insane by friends, peers, or relatives (N = 8 or 18.6%).

In terms of the providers' responses regarding obstacles to consumers receiving services, the same three variables were mentioned with the exception that they were in a reverse order. Providers reflected the belief that consumers were predominantly users of public transportation. It would appear that the providers overestimated the extent to which consumers rely on public transportation, and the possible effectiveness of the bus as a form of accessible and available transportation for the consumer.

In terms of the second variable (i.e. referral patterns), over half of the consumers were referred by another community agency, while a quarter of the sample was referred by family and/or friends (see Table 6). Two agencies were primarily responsible for most of the consumer referrals to ELAMHS. These two agencies were a large medical center complex and a local county welfare office.

TABLE 6

How Consumers make Initial Contact with the Agency as Perceived by Consumers and Providers

	Consumers	Providers
Agency	22 (51%)	15 (71%)
Family or Friends	11 (26%)	4 (19%)
Self	2 (5%)	2 (10%)
Other (Private Physician)	8 (18%)	0 (0%)

Health Systems and Perceptions of Availability of Services

A major question of the present study was whether consumers and providers knew of places other than ELAMHS that provided mental health services. Consumers were almost equally divided in response to this question, with a little more than half indicating knowledge of alternative systems. A comparison of consumer and provider responses indicated what would appear to be a logical outcome, consumers were less informed about mental health services than providers.

To further investigate the awareness and use of mental health services, both consumers and providers were asked if they thought help

with personal or emotional problems was available for E.L.A. residents when needed. An overwhelming number of the consumers felt that help was available for people in the community (N = 35 or 85%). Of those who responded negatively, a variety of reasons were given for the unavailability of services. The most frequently mentioned were: "no awareness of services", "don't know", "not enough services available", and "services not relevant".

The providers were less in agreement than the consumers about the availability of services to E.L.A. residents. A slight majority (N = 12 or 57%) believed that there were other forms of help available in the community.

Considering that potential consumers must be aware of services prior to securing them, consumers were asked whether they had ever been informed of the mental health services available at ELAMHS through the traditional forms of media outreach. The percentages of those indicating that they had been informed ranged from 9% who had obtained the relevant information from community meetings and/or newspapers to a high of 21% who had learned about services from various television programs.

As a final source of data on perceptions of available services, both consumers and providers were asked where, in their opinion, people in E.L.A. went for help with personal or emotional problems. There were some notable differences between consumers and providers on this issue (see Table 7). Approximately half of the consumers mentioned a mental health agency as most important, while about half of the providers felt that a relative was the most frequent source of help.

TABLE 7

Responses Concerning Where People in E.L.A. Seek Help for Personal and Emotional Problems

Source	Consumers	Providers
Mental health agency	19 (46%)	1 (5%)
Relative	7 (17%)	9 (42%)
Compadre or friend	1 (2%)	5 (24%)
Priest or minister	2 (5%)	2 (10%)
Medical doctor	4 (10%)	3 (14%)
Other	8 (20%)	1 (5%)

Perceptions of the Significance of Language and Ethnicity in Service Delivery

The measure of the association between providers' language and ethnicity as well as consumers' evaluation of appropriateness of services was examined. Respondents were asked a series of questions regarding bilingual/bicultural service delivery at ELAMHS. Since some of the questions were only applicable to the SS/SS consumer, responses to these questions were tabulated separately (N = 37, 6 of the 43 consumers were not SS/SS).

Consumers and providers were asked a three-part question soliciting their perceptions of the services at ELAMHS based on the language, culture, and needs of the SS/SS population in E.L.A. The total pool of consumers, the SS/SS consumer sub-sample, and the providers all agreed that services were based on the language and cultural needs of the SS/SS population in E.L.A. Measurement of statistical significance through use of Chi-Square revealed no significant differences when comparing consumers' versus providers' responses ($p > .05$).

In order to study consumer sensitivity to certain provider characteristics, the consumers were asked to identify their therapist. The majority of consumers (N = 27 or 64%) said that they were being seen by a Mexican American bilingual staff member. The most frequently identified bilingual-bicultural staff members in terms of profession were social workers (N = 12 or 29%).

Consumers as well as providers were asked for their perceptions of the helpfulness of ethnicity and the use of the Spanish language. In comparing their responses, a significant difference ($p < .005$) was found. Virtually all providers perceived language and ethnicity to be extremely helpful, whereas consumers were less concerned about this issue.

Consumers and providers were also asked their language preference while at ELAMHS. Consumers indicated a preference for English (N = 20 or 47%) over Spanish (N = 15 or 35%), whereas 18% (N = 8) held no preference. Analysis of the SS/SS consumer sub-sample indicated a slightly higher preference for Spanish (N = 15 or 41%) over English (N = 14 or 38%), whereas 21% (N = 8) had no preference. Providers tended to have a higher preference for Spanish (N = 14 or 64%) relative to English (N = 15 or 35%). Statistical analysis of the consumers' vs providers' responses to the language issue indicated a significant difference ($p < .02$).

Both the consumer and provider were asked to indicate what services have been most helpful. Consumers (58%) as well as providers, (71%) listed counseling as the most helpful service and medication as the next most helpful service.

The consumers were asked whether they preferred having a voice in determining what services were to be offered them. The majority (N = 28 or 69%) indicated a high interest in participation, but over two-thirds (N = 29 or 69%) of them were unaware of the existing community participation mechanisms and processes available at ELAMHS. This could be seen as a potential or existing barrier to actual participation by consumers in the development of effective services to the SS/SS population.

Consumer and Provider Perceptions of Unmet Mental Health Needs and Community Problems

Consumers and providers were presented with an open-ended question regarding their perceptions of services assisting E.L.A. residents to cope with personal and emotional problems. Comparison of consumers' and providers' responses indicated that whereas providers felt the need for expansion of present services, a high number of consumers perceived no need for additional services. Explanation of this difference in perception may be attributable to the overall satisfaction with services at ELAMHS by the consumers, creating the feeling among them that present services were sufficiently well developed.

As for providers, approximately a quarter of them felt that expansion of day treatment services was desirable whereas the majority of them indicated a need for the development of special mental health and social services, such as: evening services, a 24-hour emergency mental health center, and inpatient facilities.

Both consumers and providers were asked to identify the most serious problems in the community. The most frequently mentioned by the consumers was that of "drugs" (N = 23 or 55%). The second most frequently mentioned (N = 13 or 32%) was the problem of youth gangs and the assaults and vandalism associated with such groups. Finally, the third most frequently mentioned problem was that of "poverty" and/or a "lack of adequate occupational opportunities" (N = 6 or 15%). It is interesting to note that all three problems could be easily interrelated, and all are usually associated with lower socioeconomic communities.

As for providers, their most frequently mentioned responses were poverty (N = 13 or 55%), alcohol (N = 8 or 36%), and drugs (N = 6 or

22%). Although "gangs" was a commonly mentioned problem by consumers, it was only suggested by one provider.

Consumer and Provider Perceptions of the Causes of Mental Health Problems

The final research question centered around the consumers' and providers' perceptions of the causes of emotional problems. Although there was a great diversity of reasons given by the consumer, three of the more important factors mentioned were: standard of living, family problems, and childhood problems. The providers also discussed a variety of reasons for the causes of emotional disorders, and again, standard of living seemed to be an all encompassing category (see Table 8).

Discussion

It is a well documented fact that the SS/SS have traditionally underutilized mental health services in the U.S. (Padilla and Ruiz, 1973). This

TABLE 8
Consumer and Provider Perceptions of the Causes of Emotional Problems*

Causes	Consumers	Providers
Lack of early mental health prevention	1 (2%)	
Religion		1 (5%)
School problems—education		1 (5%)
Standard of living	6 (15%)	15 (67%)
Powerlessness	1 (2%)	
Drugs and alcohol	3 (7%)	
Unemployment	3 (7%)	1 (5%)
Family problems	8 (21%)	1 (5%)
Parent education	2 (5%)	
Culture shock		2 (8%)
Relational conflict	2 (5%)	1 (5%)
Childhood problems	6 (15%)	
Physical condition	2 (5%)	
Problems in living	3 (7%)	
Nervousness	3 (7%)	
Hereditary	1 (2%)	

*Data in each cell has been combined for first, second and third responses.

pattern was not evident in the present study which found that approximately 85% of the consumers sampled for study were SS/SS. Caution should be used in generalizing this finding, however, since only one agency in one community was investigated, and it is not known to what degree this agency is representative of other mental health facilities in other settings.

Previous census figures have estimated Mexican American population as attaining an average of 9 years of education. The present sample (which included 15% non SS/SS respondents) reflected a higher educational level. It is questionable whether there is a relationship between educational achievement and mental health problems, or whether higher levels of education facilitate willingness to use mental health resources.

Two sets of factors were important in consumers obtaining services: awareness of services and the pattern of consumer referral. The relationship of these two factors had been conceptualized by the researchers as constituting the "critical path" the consumer takes in receiving services. A more thorough investigation of the relationship of these factors would appear warranted. For example, in what manner does "critical path" act as a screening device in the kinds of clients seeking assistance from an agency? The fact that less than half of the consumers knew about services other than those offered by ELAMHS indicates that it is likely that many community resources are not being adequately used. Further investigation is needed to understand why traditional means of informing the community have been ineffective. For example, it may be that personal communication as opposed to more formal means of communication is an important avenue of communication in SS/SS areas.

It was surprising that relatives, compadres or friends, as well as priests and ministers were mentioned relatively *infrequently* in comparison to a mental health agency, especially since these are often hypothesized as alternative, informal sources of help in the literature. This may have been a function of the sample since many have been forced to turn to an agency when familial resources failed to provide the appropriate assistance.

A significant finding was that consumers did not perceive ethnicity and the use of Spanish as helpful, whereas the providers held virtually an opposite perception. One reason for this unexpected finding may be attributable to the consumer sample having a bilingual-bicultural staff readily available to them, and thus not perceiving the language/ethnicity issue as of critical importance.

In general, consumers were satisfied with the services they received. It is evident that providers remained aware of the cultural/bilingual

factor and its impact on the personal satisfaction and improvement of the consumer. This awareness and its incorporation into the service delivery may have positively affected consumers' satisfaction with services. Is this high level of satisfaction representative of the entire population served by ELAMHS or simply the opinions of those who have chosen to remain with the services? An adequate response to this question requires a follow up study that analyzes the non-active cases of the agency.

Regarding language, the total consumer population indicated a higher preference for English over Spanish, the SS/SS sub-sample indicated the opposite. This outcome leads us to conclude that the SS/SS consumer population was a heterogeneous group in which both Spanish and English are interchangeable languages. This variety in language preference must be taken into account in the planning and delivery of mental health services. It is recommended that the majority of direct service mental health staff be bilingual and bicultural so as to optimally meet the language, communication, cultural needs of the SS/SS consumer.

Further research might also look into the differences between those consumers who preferred English and those who preferred Spanish. The findings would aid providers in the planning of mental health services and the selection of modalities to be used in the SS/SS communities.

Innovative Interviewing Style

During the period in which the pretest interviews were being conducted, it was discovered that the standard interviewing principles had to be modified. Traditionally, interview training has focused on maintaining a certain distance from the respondent as a way of minimizing bias.

In order to elicit meaningful responses from the SS/SS respondents (especially the Spanish-speaking), it was found that there was a need to establish a meaningful relationship between the interviewer and the respondent. One means of doing this was by requiring that all interviewers be bilingual and bicultural. Another means was the use of "la platica". For example, prior to the actual interview, and at times during the interview itself, the interviewers would engage in discussions of tangential issues not directly related to the research project. Other elements of "la platica" included discussing one's own personal background (e.g., birthplace, where one had been reared, present status, etc.). Particularly important was the need to proceed at the pace and response sequence of the respondent. This included prolonging the interview process, when indicated, beyond the time needed to cover specific questions. It was

found that by engaging in "la platica" during the interview process, the establishment of rapport was facilitated, and this, in turn, helped to elicit more meaningful responses. Any further research in the Chicano community should take this dynamic into account in eliciting more fruitful responses.

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MEXICAN AMERICAN DROPOUTS IN PSYCHOTHERAPY AS RELATED TO LEVEL OF ACCULTURATION

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Statement of the Problem

When Mexican American communities encounter the dominant society, the conflict in cultural values frequently presents monumental problems for both those attempting to provide social services as well as those in need of such services. No small part of this difficulty exists in the mental health area where professionals equipped with traditional modalities are continually confronted by Mexican American clients possessing markedly different life experiences and cultural values. Questions regarding the ultimate responsibility in overcoming these barriers frequently precipitates conflict and confusion between mental health administrators and leaders in the Mexican American community.

The problem becomes more perplexing when it is discovered that Mexican Americans generally refrain from utilizing mental health services currently available (Miranda, 1974; Sue, McKinney, Allen, and Hall, 1974). Mexican Americans are found to drop out of therapy at the rate of approximately 60% following the initial interview and as high as 85% prior to the fifth session, relative to 35% and 55% for non-Mexican Americans, respectively. Inquiries into this dilemma have seen the emergence of explanations such as: a) Mexican Americans fail to utilize traditional mental health services because of their higher tolerance of and/or definition of deviant behavior; b) Mexican Americans fail to utilize services due to their preference for "naturalistic" systems more in

keeping with the primitive/religious roots of their culture and c) they may be admitted to mental health facilities, but receive inappropriate forms of treatment relative to other clients.

The belief that Mexican Americans do not use mental health facilities because of their greater tolerance of deviant behavior, or because they define mental illness in significantly different ways in contrast to Anglos, finds little support from attitudinal studies conducted in this area. Karno and Edgerton (1969) gathered quantitative data on the perceptions, definitions, and responses to mental illness held by Anglo and Mexican residents of two East Los Angeles communities. Their research approach was to conduct systematic interviews of 668 households. Analysis of their data led to the following conclusion:

> "We do not believe that the under representation of Mexican Americans in psychiatric treatment facilities reflects a lesser incidence of mental illness than that found in other ethnic populations in this county. For example, our data indicates that large numbers of Mexican Americans in East Los Angeles seek treatment for obviously psychiatric disorders from family physicians. In response to our interviews, it might be added, Mexican Americans in our study expressed the conviction that they often suffer from psychiatric disorder."

The contention that Mexican Americans prefer "naturalistic" systems of mental health as opposed to traditional services finds little support in current research. Edgerton, Karno and Fernandez (1970) studied faith healing within a Mexican American community to determine the extent of folk psychiatry being practiced. While acknowledging its existence, these researchers found the use of the system to be minimal and that it could not be used to explain the under-utilization of health services.

Belief in the widespread existence of naturalistic mental health systems has motivated many mental health administrators to allow "the Mexicans" to do their thing, in lieu of directing their resources toward the development of improved intervention techniques. People with little money and/or ability to influence change in social service delivery systems are by necessity forced to seek other alternatives for assistance. However, the point is whether this turning to "one's own" is the preferred solution as opposed to being the only available alternative.

The under-representation of Mexican Americans in mental health facilities must be considered from the perspective of an interacting complex of social and cultural factors. Within this complex is the serious barrier that "bureaucratic-like" mental health agencies present to the Mexican American. The series of embarrassing questions and forced

exposure which Mexican American clients must confront in seeking assistance frequently causes feelings of vulnerability which can immobilize their initial motivation to engage in the therapeutic process. This process, resulting in lowered self-esteem and frequently felt by the Anglo client as well, is greatly heightened for the Mexican American. The addition of other obstacles such as language, unfamiliarity with agencies, and fear and hostility toward Anglos can create a state of crisis for the individual, negating his or her desire for assistance. Questions continue to exist as to whether the major problems reside at the interpersonal level (between therapist and client) or at the institutional level via formal and informal policies of mental health centers. In addition, the question of how the variable of acculturation interacts with these two levels continues to be neglected. Clearly, any attempts to ameliorate the situation through effective planning and implementation of mental health services to the Mexican American population requires the development of relevant questions and the designing of studies directed toward answering these questions.

Continuous vs Discontinuous Clients in Psychotherapy

The literature on Continuous vs Discontinuous patterns in therapy reveals that a multiplicity of variables must be considered to account for the reasons some clients drop out prematurely while others remain. Continuance vs. Discontinuance in therapy can best be viewed in terms of the total situation involving environmental circumstances, personal attributes, and the client-therapist relationship. While there is no explicit evidence that Continuance vs Discontinuance is directly related to therapeutic gain, indirect evidence suggests that *length of treatment* is positively related to therapeutic success.

In relation to the Mexican American client, the issue of cultural conflict must be considered in understanding the reasons for premature termination. The fact that Mexican Americans are usually forced to interact with a middle-class oriented mental health agency sets up a variety of interpersonal problems. While disagreement exists as to the "best" atmosphere for therapeutic gain, it is generally accepted that positive growth is enhanced in a setting utilizing cultural and societal variables consistent with an individual's sense of self-worth. The absence of opportunities to meet culturally determined needs in a setting where ethnicity may be viewed as a barrier towards personal growth constitutes a gap between individual aspiration and the perception of personal adequacy. This gap becomes the source of a great deal of mental anguish and can lead to the eventual termination of the therapeutic relationship.

Viewing the therapeutic relationship from this broader perspective as opposed to the myopic "illness model," it becomes apparent that Mexican American clients, relative to their non-ethnic counterparts, are generally hampered in achieving their therapeutic goals. With this in mind, it becomes less difficult to comprehend the high Mexican American dropout rate in therapy.

General Hypothesis of the Study

Conclusions about Mexican Americans entering and remaining in therapy suggest a strong relationship to the ability to identify with those middle-class values underlying the goals of psychotherapy. More specifically the hypothesis to be tested is that: Mexican American clients demonstrating both a psychological as well as a behavioral identification with the dominant culture will be more likely to seek as well as remain in psychotherapeutic relationships. In contrast, those Mexican Americans exhibiting greater "cultural boundedness" will more likely express less interest in entering as well as remaining in psychotherapy.

Methodology

Design of Study

In order to study the relationship between a client's level of acculturation and their length of stay in psychotherapy, two groups of subjects (i.e. Continuous vs Discontinuous clients) were developed on the basis of the number of therapy sessions they had attended. The Continuous group was operationally defined as consisting of subjects who had attended 5 or more therapy sessions following their initial intake interview. The Discontinuous group consisted of those subjects attending no more than 2 sessions following their intake interview.

Identification of the subjects for inclusion in the study was obtained from the case files of two community mental health centers and a large county operated medical center with a University affiliation. All three of the facilities are located in the East Los Angeles area where approximately 76 percent of the population is of Mexican descent.

All of the subjects included in the study were individually interviewed. Questions pertaining to their perception of the therapy experience as well as various measures of acculturation were administered. In all cases, the interviewers were bilingual-bicultural and each of the clients interviewed was offered the option of conducting the interview in English or Spanish.

Analysis of the data consisted of comparing the responses of the subjects in terms of their group affiliation, i.e. Continuous or Discontinuous subjects. Data relating to the level of psychological and behavioral acculturation as well as perception of the benefit of therapy were analyzed for statistical differences. Demographic variables were also analyzed for purposes of examining the comparability of the two groups on relevant social-economic variables. In order to control for the interactive effect of the therapist's ethnicity, only subjects having seen a bilingual-bicultural therapist were selected for study.

Sample

Sixty records of adult Mexican American females (age 21-55) having sought mental health services during the period of January 1973 through December 1975 at the three previously mentioned centers were examined for possible inclusion in the study. Only those cases meeting the requirement of a Continuous client (5 or more therapy visits) or a Discontinuous client (2 or less visits) and having seen a bilingual-bicultural therapist were placed in the eligible sample population. This resulted in a total population of 246 clients (87 Continuous clients and 159 Discontinuous). From this population a total of sixty subjects (30 Continuous clients and 30 Discontinuous clients) were randomly selected. A randomly selected replacement list was developed for both groups in situations where the originally selected subject could not be located or refused to participate.

In addition to identification of the subject, extensive data was collected for each subject in the following areas: a) number of therapy appointments attended; b) initial assessment of subject's problems c) sex of therapist, d) professional status of therapist and e) the subject's background variables of: marital status, educational level, gross monthly income and generational level (i.e. place of birth, place of parents' birth, and place of grandparents' birth).

Measurements

Previous acculturation studies (e.g. Thompson, 1948; Rapaport, 1954; Jessor, Graves, Hanson and Jessor, 1968) have strongly recommended the need to obtain psychological measures of acculturation in addition to the usual measures of behavioral adaptations. Changes in behavior, the easiest to observe, have received primary attention, while changes in psychological acculturation have been relatively neglected. Failure to obtain some indices of psychological change seriously reduces the validity of construct inferences one can make in studying the relationship of acculturation levels to other socio-psychological variables. In

response to this potential problem, the present study employed a procedure developed by Graves (1968) to measure acculturation at both the psychological and behavioral level.

Psychological Acculturation: Among the many aspects of psychological acculturation which distinguish the various cultural groups, three have particular theoretical relevancy to the present study's concern with psychotherapy: a) interpersonal behavior, b) feelings of personal control and c) future time perspective. These correspond roughly to Kluckholn's "value orientations" with respect to man's relation to man, man's relation to his wider environment, and man's relation to time (Kluckhohn and Strodtbeck, 1961).

Measurement of Interpersonal Behavior was obtained through use of an 18-item anomie scale developed by Jessor *et al.* (1968). The theoretical basis of the scale derives from the overall community interaction system in which members of that community (irrespective of ethnic identification) participate. The normative structure guiding conduct in this community interaction system tends to be the normative structure of the Anglo majority group. In other words, members of the minority group (in this case, Mexican Americans) are under pressure to learn the normative expectations of the Anglo group in everyday situations. Consequently, the operational definition of "psychological acculturation" for any subgroup is its degree of consensus with the empirically defined norms of the majority group. Low psychological acculturation, thus, will be defined as a relative lack of consensus about the standards of appropriate behavior in common community roles, as these standards are defined by the Anglo group.

Measurement of the Feeling of Personal Control was obtained through use of a 15-item scale gauging the concept of belief in *internal* versus *external* control (I-E). The I-E concept refers to a dimension running from internal control, a belief that one has control over and can influence the consequences of one's behavior; to external control, the belief that what happens to one is governed largely by fate, luck, chance, or powerful external forces. The scale is a modification of the forced choice I-E inventory constructed by Liverant (1958). The test format involves pairing one statement expressing a belief in personal control against another expressing a belief in external control, with both items equated for social desirability. The I-E inventory is scored so that the higher the score, the greater the belief in external control.

A modified version of the Wallace (1965) Life Space Scale was used as the measure of Future Time Perspective. Theoretically, the scale attempts to determine the degree to which an individual thinks about and is concerned with various past implications and future consequences

of his actions. In terms of test format, each subject was asked to look ahead and identify five things that they think they will do or think might happen to them. Following the identification of five events, the subjects were asked to estimate how long it would take for each of the five events to occur. The assumption underlying this technique is that a legitimate inference can be drawn from this sample of future events to the temporal extension of the subject's psychological field as a whole. Operationally, future time perspective is defined as the median time from the present of the five future events expected.

Behavioral Measure of Acculturation: The level of behavioral acculturation refers to the differential availability of legitimate access to the valued goods of the dominant culture. For such access to occur, three conditions within the contact situation are minimally required: adequate *exposure* to the beliefs and behavior of the dominant group; *identification* with the dominant culture as a new reference group; and *access* to the valued resources or goals of the dominant society (Chance, 1965; Graves, 1967).

Following the model developed by Graves (1967), three measures of these more overt aspects of behavioral acculturation were employed. The first of these three measures simply taps the amount of formal education each respondent had received (i.e. *Exposure*). The measurement consists of a seven point scale ranging from no schooling to the completion of college.

The second measure consisted of a 9-item Acculturation Index (i.e. *Identification*). These 9 items are indicative of voluntary association with the dominant community and adoption of its symbols, rather than simple minimal accommodation to the requirements of the contact situation. Representative items are: "I have lived in a town rather than the countryside" and "English is spoken as the main language in my present home". These items require either, "yes" or "no" responses. Affirmative responses are scored as 1, yielding a possible range of 0 to 9.

The third measure consisted of looking at the subject's listed occupation (i.e. *Access*). The rationale behind this measure is attributed to the belief that economic position is perhaps the most sensitive indicator available in gauging command over the rewards and resources of the dominant society. Each subject's present job was classified along a seven point scale, ranging from unemployed through professional work.

Problem Identification

An open-ended question as to the client's reason for seeking psychotherapy was asked of each of the subjects. They were encouraged to provide as much detail as possible. The responses were categorized into

one of three possible categories: a) problem attributed entirely to some outside source (e.g. such as husband's alcoholism or occupational difficulties), b) a mixture of external factors coupled with intrapersonal factors (e.g. such as the inability to get along with one's mate due to personality problems on both parts) and c) problem attributed entirely to intrapersonal difficulties (e.g. such as unexplainable depression or nervousness where the individual does not feel that the environment is a factor in their difficulty).

Therapeutic Process Questionnaire

An open-ended questionnaire designed to measure client perception of the therapeutic process was developed. Basically, the questionnaire focused on such factors as: a) therapist effectiveness and concern; b) therapeutic techniques utilized; c) institutional factors that facilitate and/or impede service delivery; d) personal expectations of what therapy was going to provide; e) personal assessment of gain (as well as why or why not gain occurred); and f) overall evaluation of effectiveness of psychotherapy for Mexican Americans.

Administration of the Interview

Trained bilingual-bicultural interviewers were responsible for conducting the interviews. Intensive training in interviewing involving lectures, role playing, and independent practice was provided. All subjects were interviewed in their homes unless an alternative was preferred. The interviews were conducted in either Spanish or English. The entire interview process was completed within an hour.

Results

Demographic Variables

A comparison of means and standard deviations (or percentages where appropriate) for the Continuous *vs* Discontinuous groups on selected background characteristics may be found in Table 1. With the exception of generational level, none of the demographic variables differed significantly between the two groups. In terms of the generational level, 78 percent (N = 23) of the Discontinuous group were born in Mexico relative to 23 percent (N = 7) of the Continuous group. For those married subjects, 65 percent (N = 13) of the Discontinuous subjects were married to men of Mexican birth, relative to 33.3 percent (N = 6) of the Continuous groups. The comparability in generational status for married subjects and their husbands, irrespective of group status,

contributes to the perception that the two groups fall at significantly different points along the acculturation dimension.

TABLE 1

Therapy Group Differences on Demographic Variables

Demographic Variables	Means and Standard Deviation		Significance of Differences
	Continuous Group (N=30)	Discontinuous Group (N=30)	
Age	Mean 31.6 S.D. (7.4)	34.7 (9.7)	t = 1.00 p > .05
Family Size	Mean 2.1 S.D. (1.4)	2.8 (1.7)	t = 1.25 p > .05
Education Level	Mean 3.8 S.D. (1.5)	3.3 (1.1)	t = 0.77 p > .05
Occupational Level	Mean 2.9 S.D. (1.6)	2.4 (1.9)	t = 0.77 p > .05
Marital Status (percent married)	66.7%	60.0%	X^2 = .14 p > .05
Generation Level (percent born in Mexico)	78%	23%	X^2 = 8.53 p < .01

Level of Psychological Acculturation

Table 2 presents the Continuous vs Discontinuous group means and standard deviations on each of the three measures of psychological acculturation; as well as t-tests for the significance of group differences. On both the Interpersonal Behavior and the Personal Control Scales, Continuous subjects demonstrated a significantly higher level of acculturation relative to the Discontinuous subjects. A statistically significant difference did not exist between the two groups on the Future Time Perspective Scale.

The fact that the Continuous subjects demonstrated higher acculturation scores on the Interpersonal Behavior Scale indicates that they are inclined to subscribe to the "individualistic equalitarian" ethic reflective of the value orientation of the dominant society. Considering that the literature frequently describes the various psychotherapeutic modalities as possessing a middle-class value orientation, higher scores on this acculturation scale seems compatible with the tendency to remain

TABLE 2

Therapy Group Differences on the Psychological Acculturation Scales

Measures of Psychological Acculturation	Means and Standard Deviation		Significance of Differences
	Continuous Group (N=30)	Discontinuous Group (N=30)	
Interpersonal Behavior	Mean 15.2 S.D. (1.8)	11.5 (1.5)	t = 6.17 p < .001
Personal Control	Mean 8.4 S.D. (3.6)	5.7 (3.3)	t = 2.08 p < .05
Future Time	Mean 1.3 S.D. (2.2)	1.1 (2.4)	t = 0.24 p > .05

in a therapeutic relationship. Lower levels of acculturation in this area, as demonstrated by the Discontinuous subjects, may represent a value clash that precipitates the tendency to terminate therapy prematurely.

As for the significant difference on Personal Control between the two groups, Continuous relative to Discontinuous subjects tend to perceive that the development of their life style is directly contingent upon their own actions. Lower scores on this scale, as demonstrated by the Discontinuous subjects, is indicative of the belief that outside forces, such as powerful others, luck or fate are responsible for the quality of one's lifestyle.

Since most therapeutic modalities accept the premise that the client is primarily responsible for development of the therapeutic relationship, an unusually difficult situation is created for those clients perceiving the resources for change to rest in the therapist's abilities. The tendency to internalize responsibility for behavioral outcomes, as apparently the Continuous subjects have, clearly facilitates the ability to remain in the therapeutic relationship.

A non-significant difference between the two groups on the future Time Perspective Scale suggests that the ability to delay gratification for the accomplishment of long range goals is not a characteristic that distinguishes one therapy group from the other. It would appear that both the Discontinuous subjects as well as the Continuous subjects possess sufficient ability to work toward future behavioral changes,[1] but the

[1] Comparison of the means of both the Continuous group (M = 1.3) and the Discontinuous Group (M = 1.4) with an Anglo sample (M = 1.4) reported by Graves (1967) reflect no significant differences among the three groups.

manner in which the accomplishment of these long range goals is being conducted is incompatible with the expectations of the Discontinuous group.

Level of Behavioral Acculturation

Table 3 represents therapy group means and standard deviations for each of the three measures of behavioral acculturation, as well as t-tests for the significance of group differences. While neither the occupational level nor the level of obtained education differed significantly between the two groups, there was a tendency for the Continuous subjects to indicate higher levels of education as well as occupational ratings.[2]

The lack of a significant difference between the two groups on the educational and occupational variable indicates that the tendency to continue in therapy can *not* be attributed to social-economic-status (SES). The SES variable is generally considered (e.g. Blenker, 1955) to be one of the major explanatory variables for premature dropout rates in psychotherapy. The fact that SES differences did not exist between the two groups strengthens the argument for level of acculturation as a major contributing variable in explaining differential therapy continuance patterns.

The significant difference between the two groups on the Acculturation Index suggests that higher scores by the Continuous subjects indicates a willingness to both voluntarily associate with the dominant community

TABLE 3

Therapy Group Differences on the Behavioral Acculturation Scales

Behavioral Measures of Acculturation	Means and Standard Deviations		Significance of Difference
	Continuous Group (N=30)	Discontinuous Group (N=30)	
Education Level	Mean 3.8 S.D. (1.5)	3.3 (1.1)	t = 1.06 p > .05
Acculturation Index	Mean 5.6 S.D. (1.8)	3.1 (0.9)	t = 5.28 p < .001
Occupation Level	Mean 2.9 S.D. (1.6)	2.4 (1.9)	t = .78 p > .05

[2]For subjects who were married but not working, the husband's occupation was recorded.

as well as a receptivity to adopting their symbols (i.e., membership in formal clubs or organizations).

The Discontinuous subjects reflect a minimal accommodation to the requirements of effective interaction with the dominant culture. Analysis of their response patterns to the 9-item Acculturation Index generally presents an individual reared in a rural setting; has little contact with Anglos in employment settings; watches Spanish-language programs on television; has few or no Anglo friends; prefers to speak Spanish as opposed to English; and continues to identify with the Mexican as opposed to the American culture.

An item-by-item analysis of the Continuous subjects' responses to the Acculturation Index profiles an individual who has been reared in an urban setting; has worked a minimum of two years in employment settings dominated by Anglos; has dated Anglos and indicates a willingness to continue to do so; prefers to speak English; has a number of close Anglo friends; and identifies with the American as opposed to the Mexican culture.

The willingness of the Continuous subjects to engage and accept the dominant culture, as well as its values, places them at a relatively high level of behavioral acculturation. Their greater familiarity with the Anglo value-set (e.g., "world view") due to their frequent interactions with the dominant population may explain their increased willingness to react positively (or perhaps only patiently) to the existing mental health delivery system.

Problem Identification

Table 4 presents percentages and frequencies for the two groups in terms of their reasons for seeking therapy. As discussed in the *Methodology* section, responses to an open-minded question as to why the subjects sought treatment was content analyzed and categorized into one of three problem areas. Quite surprisingly, the Discontinuous subjects predominantly attributed their problems to intrapersonal difficulties (e.g. personality deficits, chronic depressions) as opposed to external factors (e.g. poor employment situation, disturbed child or husband). The Continuous subjects, on the other hand, tended to perceive external factors as playing a significant role in their presenting problem.

This finding is unexpected when one considers that current literature on psychotherapy suggests that premature dropouts in psychotherapy generally manifest concrete or externally oriented problems (e.g., Goldstein, 1973) as opposed to abstract, intrapersonal concerns. The fact that 76.6% of the Discontinuous subjects complained of problems that

were basically psychoneurotic in nature, whereas only 36.7% of the Continuous subjects manifested such complaints, may be a reflection of the severe identity problems experienced during the early phases of the acculturation process. Considering that the Continuous group is demonstrating a relatively high level of both psychological and behavioral acculturation, their concerns may be less focused on identity issues and more directed toward improved interpersonal relationships.

TABLE 4

Therapy Group Differences or Reasons for Seeking Help

Group Identification	Presenting Problem			Significance of Difference
	Externally Oriented	Mixture of Ext. and Int.	Internally Oriented	
Continuous Group (N=30)	4 (13.3%)	23 (76.6%)	3 (10.1%)	$X^2 = 10.30$ $p < .01$
Discontinuous Group (N=30)	14 (46.7%)	11 (36.7%)	5 (16.6%)	

An alternative explanation may stem from the differential psychological mindedness of the two groups. It is quite possible that highly acculturated Mexican Americans may be more willing to seek therapeutic assistance with interpersonal problems as a result of their greater knowledge of the various available modalities (e.g., family therapy, premarital counseling, group therapy). Unacculturated individuals, on the other hand, may feel that psychotherapy is basically a treatment process for the insane and has little or no relationship to everyday problems. Learning how to deal with one's husband, children, neighbors, or employer may be considered a personal responsibility that each individual should learn to handle in their own way. Professional intervention at this level may not strike them as particularly relevant.

Discussion

In general, the results support the study's major hypothesis: those Mexican American females electing to remain in psychotherapy for a minimum of five sessions demonstrated higher levels of both psychological and behavioral acculturation relative to those Mexican American females prematurely terminating therapy. This finding is consistent with the belief that identification with the major "value orientations" distinguishing

the dominant (i.e., Anglo) culture facilitates the ability to develop as well as maintain a psychotherapeutic relationship.

Whereas previous studies (e.g., Bakeland and Lundwall, 1975) generally consider the variable of low social-economic status as a major explanatory factor in high premature dropout rates, the present study found that neither level of education nor occupational status significantly related to continuance in therapy. This result provides support for the contention that differential cultural expectations, rather than social-economic status, frequently underlies the inability of the Spanish-speaking to successfully utilize traditional mental health services (Goldstein, 1973; Edgerton and Karno, 1971; and Philipus, 1970). The failure to develop a positive communication system incorporating mutually consistent therapeutic expectations frequently creates a cultural impasse preventing the development of an effective therapist-client relationship. Focusing on client limitation (e.g., low SES characteristics) as opposed to those limitations inherent in the therapeutic process can create serious problems in formulating effective treatment approaches for the Spanish-speaking.

The development of an effective client-therapist relationship requires the dual ability of understanding the clients' cultural situation as well as the cognitive processes associated with that culture. Lack of familiarity with the white middle-class medical model and its conceptualization of emotional disorder negatively affects the potential for treatment success among unacculturated clients. Maximal therapeutic gain generally occurs in an atmosphere utilizing those cultural and societal variables consistent with an individual's sense of self-worth. Creating a situation that prevents the client from actualizing their cultural needs and at the same time forcing them to discuss emotional problems in an unfamiliar manner, precipitates feelings of personal inadequacy and eventual termination of therapy. Thus, it can readily be observed why this population experiences unusually high dropout rates.

The issue of client-therapist cultural similarity is frequently discussed in the literature (e.g. Lorion 1974) as a sufficient as well as necessary condition for therapeutic success. This contention has led some agencies to employ both professional as well as paraprofessional staff with cultural backgrounds similar to the clientele they serve. While there can be no doubt that familiarity with the values reflective of the cultural identity of one's client is a necessary condition for therapeutic success, the contention that it is a sufficient condition is directly challenged by the results of the present study.

All of the subjects interviewed were seen by a bilingual-bicultural therapist, thus the opportunity to communicate in either Spanish or

English was available to all clients. In spite of this apparent matching of therapist and client cultural characteristics, those clients prematurely dropping out of therapy exhibited lower levels of acculturation relative to those clients maintaining a continuing relationship. Apparently, the availability of a bilingual-bicultural therapist did not significantly change the therapeutic environment in a direction conducive to meeting the needs of the unacculturated client.

If any significance is to be found in this outcome, it must be interpreted as a questioning of the belief that possessing a bilingual-bicultural background is a *sufficient* condition for successful therapeutic work with bilingual-bicultural clients. Conducting psychotherapy in Spanish does not assure that the therapist will avoid using therapeutic techniques consistent with the value orientation of the dominant society. The fact that most, if not all, bilingual-bicultural therapists are trained in a traditional educational setting makes it exceedingly difficult for them to develop appropriate bicultural therapeutic skills. With little else to fall back on, dependency on traditional modalities becomes the rule as opposed to the exception. The cultural gap which had been bridged by the matching of client and therapist background variables is opened again by the differential expectations of the therapeutic process.

Conclusion

This study has provided preliminary data on the relationship of levels of acculturation to "success" in psychotherapy. Demonstrating that Mexican American females remaining in a therapeutic relationship exhibit higher levels of acculturation, relative to Mexican American females prematurely terminating therapy, underlines the need for reassessing the delivery of services to those clients not identifying or familiar with the value set of the dominant culture. Accepting the premise that all therapeutic relationships are an integral part of the culture in which they occur, requires that attention be directed toward understanding the significant interrelationships existing between cultural variables and the implementation of effective therapeutic intervention.

Continued insensitivity to the high dropout rate by agencies providing mental health services in Spanish-speaking areas, calls for serious questioning of their future existence. The 1963 Mental Health Centers Construction Act mandated that services be provided to all residents within a center's catchment area. Failure to adhere to this mandate by selectively providing services in a manner that excludes certain segments of the population constitutes racist and/or irresponsible behavior. Efforts to correct this situation call for the development of research programs

attempting to identify those cultural variables requiring special consideration in the delivery of effective mental health services to neglected populations:

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PSYCHOTHERAPIST ETHNICITY AND EXPERTISE AS DETERMINANTS OF SELF-DISCLOSURE[1]

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Recent years have seen an increasing concern with the relative underutilization of mental health services by certain segments of our society, particularly disadvantaged and minority groups. The nation's second largest ethnic minority, the Mexican American, has participated only minimally in psychotherapy services. (Karno and Edgarton, 1969; Padilla, Ruiz and Alvarez, 1975).

Is the comparatively low utilization of psychotherapy facilities by Mexican Americans related to different styles of self-disclosure? Most forms of psychotherapy require the patient to articulate problems and express feelings to the therapist. Popular cultural stereotypes often picture the Mexican American male as one who is stoic and reticent in the face of emotional strife, and the female as one who may experience emotional stress but remains quiet in her suffering with little tendency to discuss her problems with others.

Little is known of the self-disclosure tendencies of Mexican Americans, though this factor could greatly affect their participation in psychotherapy. According to studies conducted by Jourard (1971) and his associates, black and Puerto Rican college students are less inclined to reveal personal information than Anglo Americans.

Grebler, Moore, and Guzman (1970) have found that a slight majority of a large sample of urban Mexican American men and women responded that they turned to people other than their relatives for help in any kind of problem, whether personal, financial, political or bureaucratic. Of further interest was the questionnaire finding that low-class respondents were especially likely to turn to non-relatives. Grebler,

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Moore and Guzman did not specify to whom the respondents tended to turn, e.g., to a friend, employer, neighbor, priest, psychotherapist, etc.

Since religion has traditionally been thought to serve a major role in the lives of Mexicans and of Mexican Americans, it would be important to know what function religion serves in the mental health status of the Mexican American. Is Catholicism, the most popular religion among Mexican Americans, very important to the psychological health of Mexican Americans? Does the Catholic Mexican American consult much with a Catholic priest for emotional problems? The answers to these questions are not readily available. Grebler *et al.* (1970) reported that while the majority of Mexican Americans are Catholics, the majority are also only nominal Catholics. However, it is quite possible that lifelong "nominal" Catholics may turn to a priest in time of emotional trouble. It is also possible that a system of religious belief, even if not accompanied by devout practice, may help maintain the individual in times of stress.

In a previous paper (Acosta and Sheehan, 1976) we reported on comparative preferences of Mexican American and Anglo American college students for psychotherapists of differing ethnicity and expertise. A prominent finding was that Mexican American students seem to rate highly the potential value of mental health services, a puzzling result when contrasted with the underutilization of such services by the general Spanish surname population. Another important finding was that Mexican American students tended to rate less highly the mental health professionals of their own ethnic group, as compared to professionals identified as Anglo Americans.

The present paper explores a dimension not reported in our previous study, that of self-disclosure styles and their possible role in the limited participation by Mexican Americans in mental health services. The data base for this paper stems from the same subjects (i.e., college students) who participated in the Acosta and Sheehan study on therapist preferences. The present study examined self-disclosure in relation to psychotherapists of differing ethnicity and expertise.

Hypotheses

The general hypothesis of this study was that Mexican American subjects would differ from Anglo American subjects in showing lower scores on a measure of self-disclosure.

Specific hypotheses were as follows: (1) Mexican Americans will show lower self-disclosure scores than will Anglo Americans to psychotherapists who are of similar ethnic identity. (2) With psychotherapists of differing ethnic identity, Mexican Americans will show greater self-disclosure than will Anglo Americans. (3) Both groups will show higher

disclosure to therapists introduced as professionals than to therapists introduced as nonprofessionals.

Method

Subjects

The two groups of subjects were volunteers from introductory psychology and sociology classes. The Mexican Americans, 52 male and 42 female, were from East Los Angeles College. The Anglo Americans, 39 male and 54 female, were from Santa Monica College. Both are junior colleges in the greater Los Angeles area, and the samples reflected the majority enrollment at the college from which they were taken. For purposes of this study, Anglo Americans were defined as white Americans, chiefly of North European stock, who were not Spanish-surnamed. Mexican Americans identified themselves as follows: Mexican American 48%, Chicano 30%, Mexican 10%, white 4%, Caucasian 6%, other 2%. It is interesting to note that even though the Mexican American subjects were all native born, 10% identified themselves as Mexican. Both groups of subjects were native born Americans fluent in English. The volunteer rate resulting from classroom announcements of the research study was approximately 85%. No subject reported a previous enrollment in a research study. Informed consent was obtained after the nature of the experimental procedure was explained.

Subjects reported the occupation of the head of the family, either father or mother. Based on the system of Hunt and Cushing (1970) each subject was accordingly assigned a socioeconomic status of High, Medium, or Low. Mexican American subjects fell into the following groups, based on parental occupation: High, 7; Medium 51; Low, 30; undeclared, 6. Anglo American subjects divided: High, 38; Medium, 40; Low, 11; undeclared, 4.

Procedure

After filling out a brief questionnaire giving demographic information, subjects answered six questions on their expectations regarding therapist behavior. They then listened to the experimenter's presentation of one of four therapist introductions, and listened to one of two matched therapy tapes. At this point, a questionnaire designed to measure self-disclosure, was administered.

The two tapes listened to by each ethnic group were matched, and contained the same dialogue. The tapes presented a therapist working for the first time with an anxious, depressed and at times angry young man. In one tape, the therapist spoke fluent English with a slight Spanish

accent; in the other tape he spoke fluent English with a standard American accent. Therapist responses included questions, silences, and reflections. The therapist was identified as being in one of four categories: Anglo American professional, Anglo American nonprofessional, Mexican American professional, Mexican American nonprofessional. The same therapist was introduced as either a professional ("Dr.") or as a nonprofessional ("Mr.") with corresponding high and low descriptions of his expertise. When the therapist spoke English with a slight Spanish accent, he was identified by a common Spanish name and it was stated that his parents came from Mexico. In contrast, when the therapist spoke English with no Spanish accent, he was identified by a common Anglo American name and it was stated that his ancestors came from northern Europe before the Civil War. Each subject was presented with only one of the two tapes and with only one of the four therapist introductions. A more detailed description of the therapist introductions may be found in a previous paper by Acosta and Sheehan (1976).

After hearing one of the tapes, each subject was asked to indicate on the self-disclosure scale, his or her degree of willingness to talk to the therapist he or she had just heard. The measure of self-disclosure consisted of a twenty-item sentence completion blank. The items included such stems as: "I often wish. . . ." "My face looks. . . ." "My biggest problem is. . . ." Each subject was asked to think about each item in a personal way that would express his or her thoughts and feelings. While asked to complete the thought, the subject was instructed not to write down the completion. Instead, the subject was asked to indicate on a four-point scale the degree that he or she would be willing to talk about each item to the therapist just heard on the tape. The four-point scale consisted of: "not at all," "almost nothing," "in general," and "fully."

As a measure of self-acceptance, each subject was asked to complete the Bentler Psychological Scale 24. Bentler (1972) developed this scale with a large group of college students and found it to be high in internal consistency and in validity. He obtained concurrent validity by correlating the scale with peer evaluations. In the present study, Bentler Scale 24 was used to determine whether any group differences in self-disclosing tendencies might be related to degree of self-acceptance.

Design and Data Analysis

The main analyses of experimental conditions were performed with a 2 x 2 x 2 Analysis of Variance. The independent variables were: Subject Ethnicity x Therapist Ethnicity x Therapist Expertise. The main dependent variables were the self-disclosure scores.

Results and Discussion

Self-Disclosure

Mexican Americans proved to be significantly lower in self-disclosure scores than Anglo Americans, as revealed by analysis of variance for all subjects. Socioeconomic status, as indicated by occupational rank, did not affect this result. Although both groups indicated a substantial willingness to disclose about themselves to the therapists, the Anglo American were somewhat higher.

Mexican Americans were found to disclose less to Mexican American therapists than did Anglo Americans to Anglo American therapists. This finding was in support of an initial hypothesis of the study. While Mexican Americans disclosed less than Anglo Americans, their mean disclosure indicated a positive tendency to disclose "in general" to the therapists. Sample differences hinting at a tendency for Mexican Americans to disclose more to Mexican American therapists were not statistically significant.

In Table 1 may be found the means and standard deviations for total self-disclosure scores for all 187 subjects. A highly significant finding ($p < .001$) appeared in the direction of lower overall self-disclosure scores for the Mexican American group. This finding is presented graphically in Figure 1.

An orthogonal varimax rotation procedure was used to factor analyze the twenty items in the self-disclosure scale. This analysis revealed five

TABLE 1

Self-Disclosure Scores for Mexican American and Anglo American Students*

	Therapist Condition							
	Anglo American Professional		Anglo American Non-Professional		Mexican American Professional		Mexican American Non-Professional	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Mexican Americans (N=94)	58.89	10.41	56.08	11.69	56.65	11.77	61.83	10.66
Anglo Americans (N=93)	65.52	13.05	64.58	10.07	63.44	8.92	63.86	14.08

*Minimum score possible: 20; Maximum score possible: 80. The higher the score, the higher the level of self-disclosure.

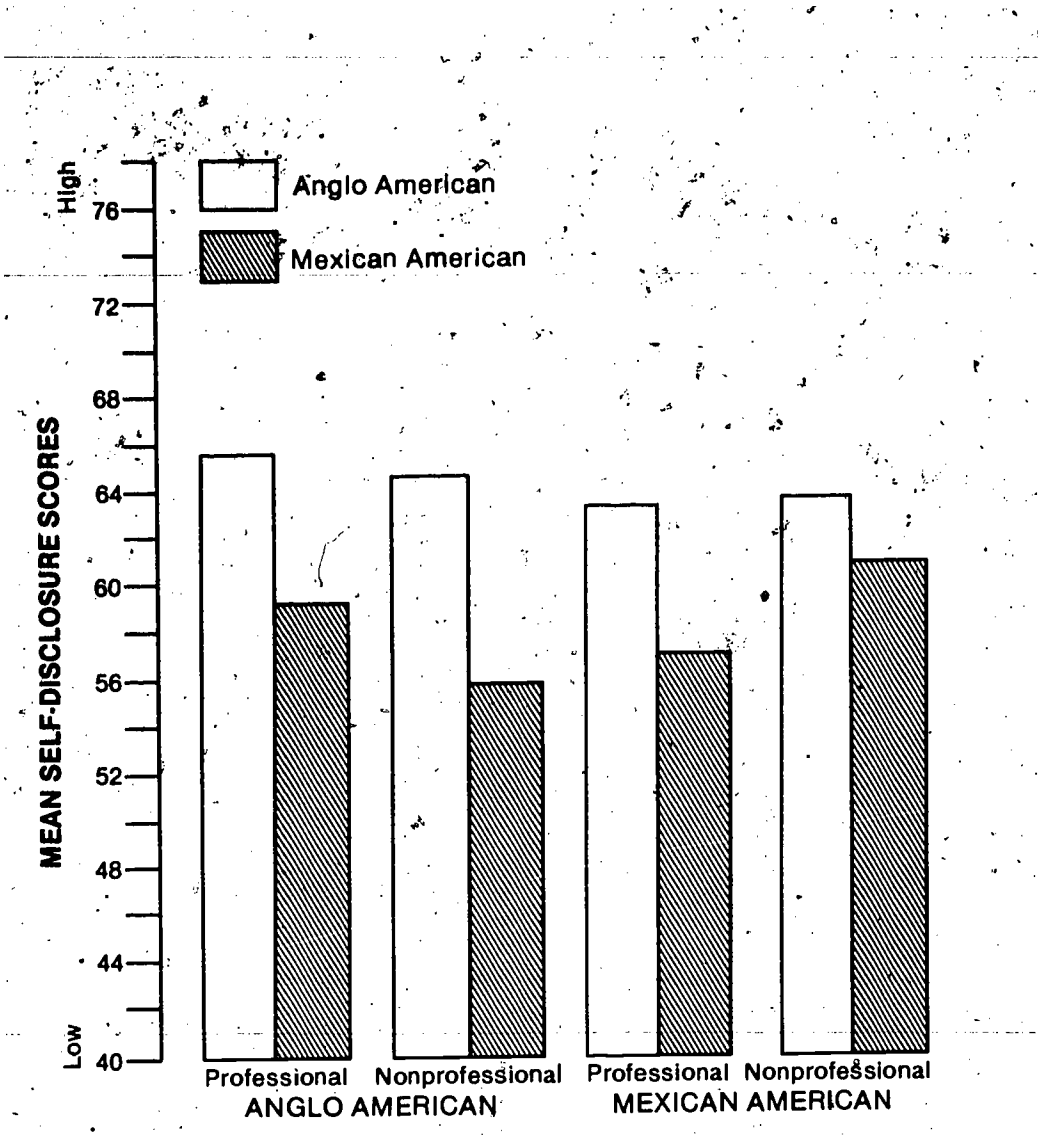

Figure 1. Means for Total Self-Disclosure Scores by 94 Mexican American students and 93 Anglo American students. Minimum score possible: 20; Maximum score possible: 80. The higher the score, the higher the level of self-disclosure. Overall group differences between the Anglo Americans and Mexican Americans were highly significant ($p < .001$).

self-disclosure factors: (1) Personal Problem; (2) Sex; (3) Work; (4) Body; (5) Dissatisfaction.

The results of the analysis of variance determined that the overall self-disclosure effect held for the following four factors: Personal

Problem ($p < .01$); Work ($p < .01$); Body ($p < .05$); and Dissatisfaction ($p < .01$).

Analyses of variance with Subject Sex as an added two-level factor revealed practically no sex differences in self-disclosure scores across all subjects. The only main effect found was on the self-disclosure Dissatisfaction Factor ($p < .05$), which revealed that females were more willing to disclose on this factor than were males across therapist conditions.

The Medium Occupation Rank provided a comparable number of subjects in the two ethnic groups to permit comparison across therapist conditions. The results are essentially as are those in the total sample, as Figure 2 shows ($p < .05$). This result indicates that differences reported here in the two ethnic groups were not attributable to differences in occupational level.

Moreover, additional comparisons were carried out within each ethnic group. In the Mexican American group, there were sufficient subjects to compare the Low with the Medium Occupational Rank. No significant differences appeared. In the Anglo American group a similarly feasible comparison of High with Medium Occupational Rank was carried out, again with no significant results.

In order to assure that the results were based on groups with homogeneous variance and thus to increase the confidence in the group differences for self-disclosure, the assumption of homogeneity of population-error variance was tested. Based on Hartley's F_{max} test as described in Kirk (1968) the two ethnic groups were found to be homogeneous in variance, and thus to represent significantly different levels of group self-disclosure.

Though there was an overall self-disclosure tendency difference between Mexican Americans and Anglo Americans, it did not hinge upon therapist conditions. In other words, the amount of self-disclosure tendency of each ethnic group did not depend upon whether the therapist had been identified as a Mexican American. It also did not depend upon whether the therapist had been identified as a nonprofessional.

Self-Acceptance Measure

It may be recalled that the self-acceptance measure employed in this study was Bentler's Psychological Scale 24 (1972). A three-way analysis of variance across all subjects revealed no significant differences. The Medium Occupational Rank showed a similar result. It is important to note, however, that both Mexican American and Anglo American subjects scored in the direction of high self-acceptance.

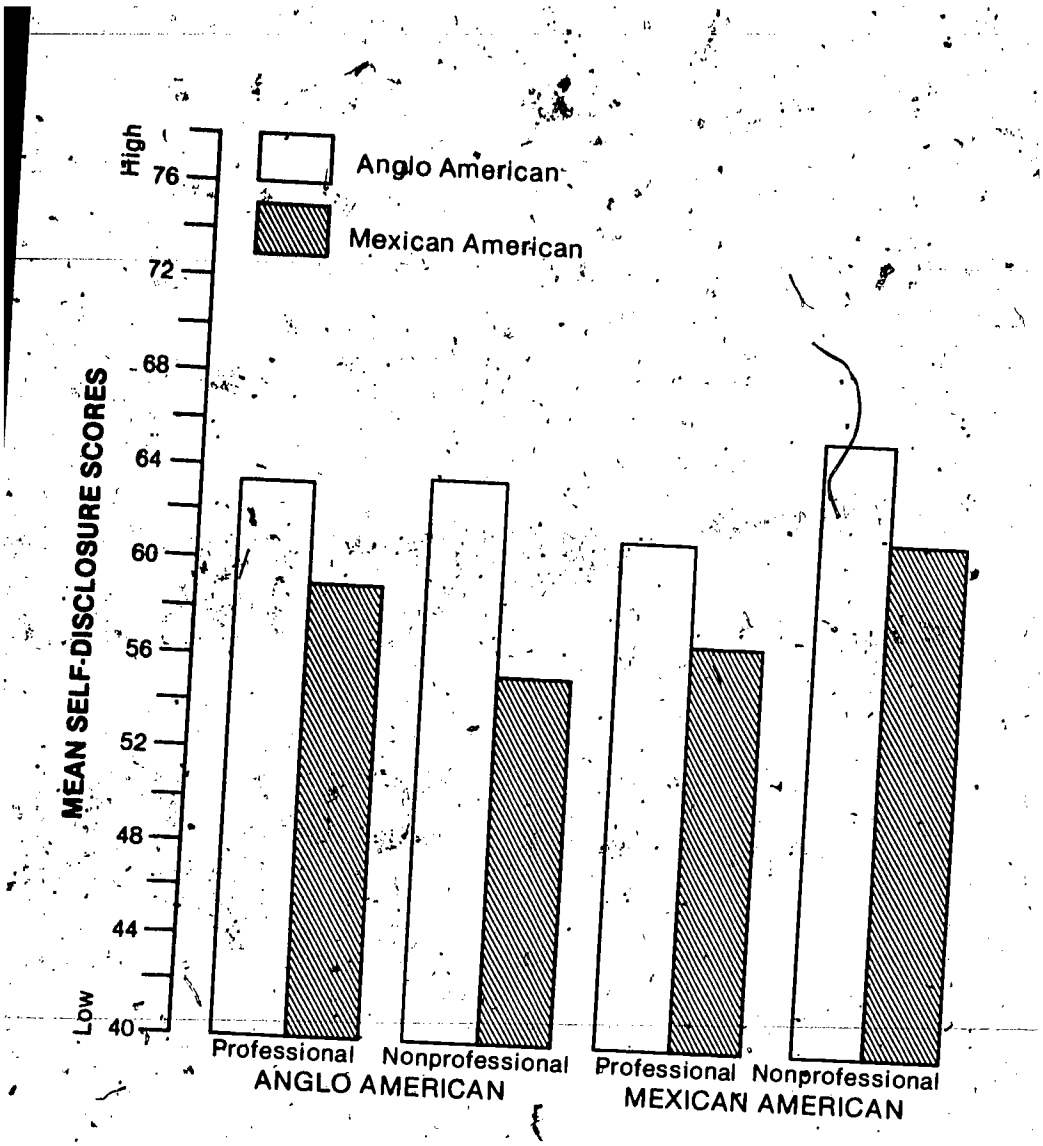

Figure 2. Means for Total Self-Disclosure Scores by 50 Mexican American students and 40 Anglo American students in the Medium Occupational Rank. Minimum score possible: 20; Maximum score possible: 80. Higher score shows higher self-disclosure. Group difference between the Anglo Americans and Mexican Americans was significant at .05 level.

The chief significant difference that did appear indicated a lower self-acceptance level for females ($p < .01$). However, both male and female scores were in the direction of self-acceptance. Stated differently, it was found that while females scored in the direction of a high degree of self-acceptance, males scored positively to a greater degree.

Conclusion

The results indicated that Mexican Americans did differ significantly from Anglo Americans in the overall self-disclosure tendency. While both ethnic groups showed some positive willingness to disclose to therapists, Mexican Americans showed significantly less willingness than did Anglo Americans. The finding that Mexican Americans showed less self-disclosure than Anglo Americans to both Mexican American and Anglo American therapists was in support of the study's general hypothesis.

The results have shown that Mexican Americans are in general willing to make self-disclosing statements to therapists. The finding appears to hold whether the therapist is professional or nonprofessional and Anglo American or Mexican American. The pattern further held across occupational levels.

It should be emphasized that both groups of subjects showed considerable willingness toward self-disclosure. The finding that the Anglo American was somewhat higher in self-disclosing tendency should not imply that the Mexican American is therefore so low as to be a poor candidate for psychotherapy. In fact, the finding that the Mexican American tends to be quite self-disclosing is one of the major contributions of this study. It is a result that stands in contrast to the relatively limited utilization of mental health services by Mexican Americans as a group.

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APPLICABILITY OF A BEHAVIORAL MODEL IN SERVING THE MENTAL HEALTH NEEDS OF THE MEXICAN AMERICAN

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There are many prevalent beliefs and practices which have impeded the delivery of efficacious mental health care to the Mexican American. These beliefs and practices have been well documented in articles such as that written by Padilla, Ruiz, and Alvarez (1975). The prevalent therapeutic practices and their failure to meet the psychological/cultural needs of the Mexican American is one area which deserves further attention. However, if therapeutic changes are to evolve, in addition to documenting the existent therapeutic shortcomings, such attention should of necessity identify and/or develop alternative and innovative therapeutic frameworks which are psychologically and culturally relevant to the Mexican American.

Basically it is the author's contention that the existent therapeutic shortcomings are the result of the basic ethnocentric belief system that permeates this society and in particular the various fields of social science. Holding to such a belief system, it is easy to assume that everything does and should revolve around the majority culture. Acknowledgement of different cultures, when given, is based on the "most obtrusive", and often superficial variables: racial features, food, music, and language. On the other hand, there is little or no understanding of the more subtle but pervasive and substantive differentiating aspects of the culture. However, these differentiating aspects which encompass such areas as human-relational processes, incentive-motivational styles, and learning styles are unique and of direct relevance to life adjustment. Without sensitivity and recognition of these important yet subtle cultural differences, it can be said that the person of a different culture is actually perceived as acultural, ahistorical, and, if you will, "apsychological". With such a limited and a much too frequent erroneous perception of the culturally different person, it then becomes quite easy for the therapist to ethnocentrically assume, without any empirical knowledge, that it is possible to effectively treat all individuals from different ethnic backgrounds using standard traditional and static psychological approaches. However, if therapy is to be effective, the cultural values the client brings with him must first be understood (Aguilar & Wood, 1976), and the

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treatment approaches must be modified to meet the distinct needs of the culturally different person.

It would appear that a prerequisite for providing effective therapy for the Mexican American is a respectful understanding and acceptance of psycho-cultural differences in human-relational, incentive-motivational, and learning styles. For instance, in the area of human-relational styles, the importance of the family, and in particular the extended family, must be carefully studied and understood as a possible therapeutic vehicle. Of equal therapeutic merit is the acknowledgement of the significance given by the Mexican American to the spirit of cooperation as opposed to that of competition (Kagan & Madsen, 1971). With respect to incentive-motivational styles, recognition should be given to the differences which may exist in one's perception of locus of control as a result of one's ethnicity. Initial research indicates that the Mexican American, when compared to the Anglo, tends to exhibit more external locus of control (Castaneda, 1972). If further research should verify this, there would be direct therapeutic implications. There is also evidence, relevant to the provision of effective therapy, that the Mexican American, unlike the Anglo, demonstrates a greater degree of motivation when seeking to succeed for others (i.e., family, ethnic group) rather than for self (Ramirez & Castaneda, 1974). In the area of learning styles, Ramirez and Castaneda have identified differences in learning styles (i.e., different methods of approaching and solving problems) between ethnic groups. Such findings, again, are important in the development and provision of culturally appropriate therapeutic procedures.

However, because of the static and closed nature of traditional psychotherapeutic approaches, the awareness and the understanding of both the obtrusive and subtle, yet very important, aspects of the culture is not suggicient to ensure the provision of relevant therapeutic help to the Mexican American. In addition to such awareness, what is needed is a dynamic and open therapeutic framework which would allow making positive use of the culture as an important and inherent variable in the therapeutic process, a framework that would tailor the therapeutic process to the individual's particular psycho-social needs and objectives.

A model that could conceivably provide this type of framework has been suggested by Davison and Stuart (1975). This model rather than using a single unitary approach encompasses a wide variety of goals and techniques. By encompassing varied goals, efforts can be directed toward changing the ways in which the individual responds to forces in the environment, or they can be expended towards changing the environment in ways that suit the individual. Being amenable to directing

appropriate attention to the environment is of great importance when working with the Mexican American, many of whose problems are created or augmented by a hostile environment.

To illustrate the option of directing therapeutic attention to either the environment or the individual, and when necessary, to both, the following hypothetical case is presented. The client is a middle aged Mexican American who is married and raising six children. His ability to express himself in English is somewhat limited. Due to particular circumstances in his life, he presently has to deal on a regular basis with a State agency in which there is no representative of the Spanish-speaking community. He finds it extremely difficult to speak up and make his requests or needs known to this agency and as a result is experiencing a considerable amount of anxiety. This anxiety is beginning to manifest itself through physiological symptoms (i.e., tension headaches) and indirectly is promoting negative interactions between himself and his family. The anxiety eventually becomes unbearable and thus professional help is sought. If this person should fortunately find himself working with a therapist who adheres to a model which encompasses a variety of goals, the therapist in conjunction with the client would first need to determine towards which goals the therapeutic process would be directed. If it were decided to focus solely on the client, the therapist would be free to employ any of numerous techniques (i.e., assertive training modeling, role-playing, etc.; relaxation training; desensitization) in helping the client cope with and eventually overcoming the anxiety caused by his inability to express himself freely. However, if the environment is the culprit, the therapist working closely with the client might want to direct attention at modifying those aspects of the environment considered to be troublesome. For example, client and therapist could develop an organized plan of action to pressure the particular agency to hire a member of the Spanish-speaking community. In choosing to deal with the environment the emphasis is placed on "working closely with the client" since it is generally accepted that it behooves any Mexican American therapist to assume a socially responsible role model in working closely with the client, within the client's own milieu, to bring about effective social change. Such efforts on the part of the therapist may not only alleviate the presenting problem but may assist in teaching the client to deal with similar problems that may arise in the future. In addition, these therapeutic gains may prevent similar problems from developing for other individuals. Unfortunately, the therapist and the client frequently do not have access to the most advantageous option, which is that of effectively working with both the client and the environment.

As previously mentioned, besides encompassing varied goals, this model also allows use of a variety of therapeutic techniques. Thus, depending on the individual's needs and goals, the therapist is free to direct attention solely or in combination to the behavioral, the emotional, or the cognitive realms. Additionally, the model makes use of those techniques that are most conducive to providing the specific help needed within each of the three realms.

To illustrate the variety of techniques the therapist can utilize in therapeutically assisting an individual, reference is made once more to the hypothetical case described earlier. The treatment techniques used with this anxious individual will depend on the way the client experiences his anxiety as well as on the cooperative way in which both the client and the therapist perceive the probable causes of the anxiety. If the client's primary concern is tied up with the physiological indicators of anxiety, the therapist may choose to first direct attention to teaching the client techniques of physical relaxation that will tend to reduce the anxiety. If the client's anxiety results from a negative self-concept maintained through negative self-thoughts/negative self-statements, the therapist may elect to alleviate the anxiety through application of cognitive behavioral methods. On the other hand, if the client's problem stems from a deficit of specific verbal responses, emphasis might be given to the development of appropriate goal directed behaviors through use of assertive training techniques. The basic principal being stressed is that of assuming that the therapist makes use of those techniques that are in accordance with the needs of the client.

Despite the variety of goals and techniques falling within the rubric of this behavioral model, the model maintains several important unifying characteristics which reaffirm its applicability to the Mexican American population. First, the focal principles and techniques have been derived from, or are consistent with, research investigations in the experimental, social and learning areas of psychology, thus making them more applicable across cultures (Davison & Stuart, 1975). Secondly, the model's main objective is the alleviation of human suffering and the enhancement of human functioning. As a third point, when responsibly practiced, this model involves a systematic evaluation of treatment outcome and whenever possible, the evaluation is actually done on a continuous basis. Needless to say, such evaluative procedures would be extremely important in determining the effectiveness of this or any model with the Mexican American client. Finally, the therapy encompassed in this model is guided by a contractual agreement between both client and therapist

specifying the goals and methods of intervention. Such participation would be of importance to Mexican American clients since it allows them to choose goals and techniques which are not contrary to their inherent cultural values, and in fact, frequently allows them the flexibility of contracting to use definite cultural attributes as the vehicles to facilitate change (i.e., the extended family).

Though emphasis has been given to the importance of positive recognition and use of the person's culture within a behavioral therapeutic framework, the therapist is cautioned against over-reacting to general cultural attributes and inaccurately assuming that all Spanish-speaking individuals are alike. One can not assume that if a therapy approach works for one it will also work for all. Making such an erroneous assumption may result in the perpetuation of inadequate therapy for the individual in question as well as the population in general. This can be prevented by carefully monitoring the diligent pursuit of the goals of this model, placing primary emphasis on the achievement of positive behavioral changes that are valued by the individual as well as the society or culture in which that individual functions.

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ASSERTIVE TRAINING WITH LOW INCOME MEXICAN AMERICAN WOMEN

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The Mexican American is undoubtedly experiencing much psychological distress. This premise is based on the following adversive social conditions which affect many members of this population: overt and covert prejudice; pervasive poverty; ineffective and/or insufficient education; extremely high unemployment and/or underemployment; overcrowded and dilapidated housing; low levels of health and health information; difficulty with English fluency; stresses inherent to acculturation and immigration; high rates of alcohol and "hard drug" addiction; and father absence due to marital disruption, incarceration, and lack of local employment.

The low-income Mexican American woman is stressed by the unfavorable psychological consequences of these factors, as well as by those associated with her consistently high fertility and by the other conditions of poverty which disproportionately burden low-income women. Additionally, her sub-assertiveness, which is probably poverty and culturally related, aggravates her disadvantaged position and increases her suffering.

This author's research (Boulette 1972), and her 9 years of clinical experience with emotionally disturbed low-income women of Mexican descent, indicate that sub-assertiveness is a frequent characteristic. Sub-assertiveness can have many destructive concommitants such as: severe and long-term neglect, emotional abuse and physical violence from her husband; limited powers to direct, influence and guide her children; reduced skill to "hustle" for limited community resources; and decreased limit-setting ability to decrease inappropriate or prejudicial behaviors and practices of landlords, teachers, caretakers, and others.

Even though such sub-assertiveness seems to be clearly aggravating these clients' problems, it is rarely discussed before the second or third interview. Initially, they describe symptoms which would be classified as hysterical, conversion-type reactions, or psychophysiological disturbances of various body systems. These symptoms are chronic and severe enough to be incapacitating. The following are frequently described: (1) severe head, neck, back, limb, or abdominal pain; (2) coldness, numbness, burning sensations or paralysis of the upper or lower limbs;

p. 66 blank

(3) inability to swallow or digest certain foods; and (4) dizziness, fatigue, blurred vision, and ringing of the ears. These symptoms are usually accompanied by profound depression and generalized anxiety.

It should be noted that of the hundreds of low-income Mexican American women treated by this practitioner, only a small number, probably less than 5 percent, attributed these distressing symptoms to such belief systems as (1) "mal de ojo" or evil eye; (2) "embrujo" or "un mal puesto" which means witchcraft or a hex; (3) "susto" or fright reaction. These folk beliefs are given much prominence and importance in the literature by clinically inexperienced Anglo and Latin social scientists.

The assessment interview with these low-income women of Mexican descent reveals; early childhood poverty; parental neglect or abuse; lack of appropriate educational and occupational opportunities; an early marriage quickly followed by childbearing; and a very stressful marital union. For example, these women describe their husbands as alcoholic, neglectful, unfaithful, domineering and sexually demanding. Emotional abuse is said to consist of threats of physical violence, withholding of affection, lack of consideration and continuous verbal belittlement of her worth as a cook, housekeeper, mother and sexual partner. Physical abuse is described as slaps, fisted blows, hair pulling and kicking. Additionally, they reported difficulty with their children who are described as "nervous", "disobedient", "disrespectful", "violent", "not doing well in school", "on drugs", or "on probation". Difficulties with teachers, caretakers, and landlords have also been reported.

The described behaviors used to cope with these difficult circumstances are usually sub-assertive in nature, such as: pleading or "rogar", crying or "llorar"; praying or "resar"; and enduring or "aguantar". These responses at best are only temporary in their effectiveness; the destructive interactions usually continue and worsen. These clients then respond with increases in irritability, startle reactions, agitation, restlessness, disinterest in grooming, social withdrawal, insomnia, depressed appetite, and multiple somatic symptoms.

Much effort is made to prevent family members and close friends from learning about these problems, since both partners want to maintain a "good front" of a "strong familia". Priests may be consulted, but little relief is reported. Physicians are frequently consulted, and advice and medication bring some relief. Spanish-speaking social workers (welfare), public health nurses, and community workers are also sought and after brief counseling and consultations, mental health referrals are made.

Considering the types of problems demonstrated and reported by these clients, assertive training may be indicated as a primary or adjunctive treatment choice. Assertive training is similar to what Moreno in the early 1930's referred to as spontaneity training. Wolpe and Lazarus (1966), Wolpe (1969), Lazarus (1972) and Liberman (1972) describe this treatment approach as consisting of a variety of behavioral techniques used for the purpose of increasing the frequency of assertive behaviors. Assertive behaviors refer to any appropriate behavior needed to set limits, protect one's rights, or to express feelings of anger, irritation, affection and concern. Unadaptive anxiety may inhibit the expression of assertive behaviors and the suppression of these strong feelings may lead to somatic symptoms or even pathological organ changes (Wolpe, 1969). Lazarus (1972) states that low self-esteem, inadequate mastery of life situations, depression, rages, and apathy are often due to problems in assertion.

The specific techniques involved in assertive training, include education, exploration of inhibiting factors, advice, modeling and behavior rehearsal (Lazarus, 1972). Typically, the technique of education is initially needed to help the client understand the relationship between her distressing symptoms and the destructive, degrading, frightening circumstances in her life. Use of concrete examples, reality-based interpretations and psychodramatic techniques may be used to facilitate this phase of education. When exploration of factors inhibiting the use of assertion is attempted, the client reports mukiple fears. Among these are: fear of provoking physical violence; fear of being deserted; fear of not being able to manage the children; fear of receiving the children's blame; and fear of her own inadequacies. Additionally reported is their limited repertoire of assertive responses. Assertive responses are said not to have been learned in childhood because their mothers rarely modeled these responses and because compliance rather than assertion was reinforced. Still further, reality-based limitations, such as limited English fluency, car driving ability and occupational skills, also inhibit their use of assertive responses.

Use of advice, or "consejos" is especially useful in assertive training, because these clients frequently lack knowledge of medical, legal, occupational, child care and other resources. Advice is also given to increase sources of emotional support and to prevent further physical violence. For example, the client may be advised: to avoid provoking her husband; to remove knives and loaded guns; to install a phone and door locks; and to seek assistance from her family, "comadres" (her child's godmother), friends and neighbors.

Assertive behaviors are explained and modeled by the therapist who encourages the client to practice or rehearse these behaviors. Care is taken to model behaviors gradually and to minimize and prepare for likely adverse reactions. Behaviors which are likely to provoke violence or other adverse responses are not encouraged. However, some clients may insist on taking these risks, saying they have nothing to lose. Care is also taken to reward spontaneously reported or demonstrated assertive behaviors. Improvement in grooming, dress, or outlook is also noted and reinforced with praise, humor and affection.

The direction of the assertive training originates with the client who decides which problem area is causing her the most distress. Beside deciding on the priority of her problems, she also considers and decides on her available alternative solutions. For example, she might feel her conflict ridden marital relationship is causing her the most distress. She may further decide she wants help to improve this relationship or to involve her spouse in counseling, or to terminate the marital relationship.

In summary, it can be stated that assertive training has been found to be well-accepted and well-utilized by low income Mexican American women who demonstrate psychophysiological symptoms, depression and generalized anxiety. In addition to assertive training and referral to needed auxiliary community services, the clients' favorable therapeutic outcomes are probably based on many other variables. One of these variables is what Moreno refers to as the "tele" or therapeutic love between client and therapist. This tele is more likely to occur if the therapist feels and demonstrates concern, interest and caring. It is also probably more likely to occur if the counselor is Spanish-speaking, familiar with poverty, and accepting of the client's need to share painful sorrow, guilt, anger, and self-pity. Another important factor is the therapist's belief in the client's ability to learn the needed skills and the approval of their right to decide to maintain, improve or terminate their marital unions. Further, the client's perception concerning the therapist's reliability and resourcefulness is another important variable that influences favorable therapeutic outcomes. Last, but certainly not least, is the therapist's ability to perceive, appreciate and utilize the client's heterogeneous cultural heritage. Preconceived cultural stereotyping is avoided. Instead the client is given the opportunity to speak Spanish and English or a mixture of both. The meaning of "chistes" (jokes), "refranes" (proverbs) and "dichos" (cultural sayings) is interwoven into the therapeutic experience according to the pace and direction which the client establishes. Cultural identity issues are not emphasized unless the client

indicates that these are problems. Religious issues are given the emphasis dictated by the client's beliefs which are very heterogeneous.

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BEHAVIORALLY ORIENTED GROUP THERAPY: A SUCCESSFUL APPLICATION IN THE TREATMENT OF LOW INCOME SPANISH-SPEAKING CLIENTS

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The most frequently discussed issue in Chicano mental health has been their reported underutilization of mental health facilities (e.g., Jaco, 1960; Karno and Edgerton, 1969; Padilla, Ruiz, and Alvarez, 1975; Abad, Ramos, and Boyce, 1974). While critically important, this emphasis has deflected attention from those Mexican American clients who do utilize psychiatric facilities and the frustrations experienced when they do seek out treatment.

This paper will report on the authors' experiences in utilizing multifocused group therapy as a treatment modality with predominantly Spanish-speaking clients at the Los Angeles County-USC Outpatient Psychiatry Department. As such, the discussion is not based on data gathered from a highly controlled investigation but rather from a set of consistent clinical observations which may be useful for further treatment planning.

The Outpatient Clinic providing the setting for the study is unique in that it is located in a community regarded as having this country's highest concentration of Mexican American residents, the East Los Angeles Barrio. Hence, at this particular clinic there exists a substantial pool of Mexican American referrals from various social class and language backgrounds.

While there are many problems attendant to the delivery of effective mental health care to this minority group, in general, the most difficult involves providing adequate services to those clients who are exclusively or predominantly Spanish-speaking. The primary problem is obvious; there is a communication barrier given the conspicuous absence of bicultural-bilingual psychotherapists (Padilla, Ruiz and Alvarez, 1975).

In addition to the communication problems, however, other factors contribute to a therapeutic impasse. Edgerton and Karno (1971) in a survey of Mexican American perceptions of mental illness and psychiatric care, found that lower class Spanish-speaking individuals were the most likely to have traditional, highly somatic, folk conceptions of mental illness and treatment. A significant portion of this sub-group retain the

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non-psychological, non-introspective, passive medical orientation to psychiatric care known to correlate with early termination from treatment. Hence, in addition to the communication barrier, many of these patients have conceptions of their illness and expectations for treatment which are at considerable variance with that of their therapist.

Therapists confronted with a non-fluent, somatizing client whom they can't understand and can't help (or don't want to help) revert to drug treatment and thus reinforce both somatic conceptions of disease and drug independence. Several treatment course analyses have shown that the lower-class, mainly Spanish-speaking patient typically is not retained for individual psychotherapy, but instead tends to receive brief supportive or directive counseling (e.g. Karno, 1966). Hence, it is often the case that the client returns with no new adaptive skills. It is not surprising that many of these patients, frustrated with the problem of being misunderstood, drop out and never receive needed psychological assistance (Yamamoto and Goin, 1965). This is particularly disheartening when one considers that these Mexican American clients have put aside the stigma of psychiatric referral long enough to show up at our treatment doorstep.

Another approach, the use of interpreters, has met with mixed feelings on the part of both client and therapist, as to whether this is really a viable treatment alternative (Kline, Acosta, Austin and Johnson, 1976). Many therapists feel that the process of evaluation, diagnosis and therapy is severely impaired via the use of interpreters. One wonders in this situation if the client is actually relating to the therapist or the bicultural-bilingual individual doing the interpreting. Unfortunately, in many situations there is no alternative.

Despite the fact that a significant portion of the surrounding catchment area in which this study was performed is predominantly or exclusively Spanish-speaking, the employment of bilingual-bicultural therapists in any quantity has occurred only quite recently. Hence, the large scale delivery of services by ethnically similar, bilingual therapists in individual or group formats has been infrequent. Given the substantial pool of mainly Spanish-speaking referrals and shortage of bilingual, bicultural therapists it was decided that the use of a multifocused group format would potentially serve as one way to increase the availability of services to the predominantly Spanish-speaking, lower class client. Before discussing some of the intervention strategies found to be successful, it would be important to briefly review relevant clinical literature supporting the feasibility of the present project.

Review of Literature

Addressing the "relative therapeutic failure" in encounters between the psychiatric institution and the Chicano community, Karno (1966) suggests that part of the problem lies within the behavior of the ethnic patient himself. In his observations, the relative passivity, deference and polite inhibited silence of the Chicano patient make him a poor candidate for psychotherapy. Others have interpreted the Mexican Americans' strong family loyalty as reflecting a general distrust of outsiders that would limit their ability to participate openly in the psychotherapy process (Heiman, Burrell, and Chavez, 1975).

Empirical research on the self disclosure tendencies of Mexican Americans is equivocal. Littlefield (1969) in a tri-ethnic comparison, found both Anglos and Blacks to report greater self-disclosure than Mexican Americans. However, this self-report data must be interpreted with caution in light of recent reviews of self-disclosure research (Cozby, 1973) that show zero order correlations between reported disclosure and actual disclosure in varied situations. Using measures with more predictive validity, Acosta (1974) found relative differences between Anglo and Mexican American junior college students in willingness to self-disclose, but noted that the self disclosure tendencies of the Mexican American groups were still quite high. In general there is no definitive research on the normative disclosure patterns of Mexican American patients. More importantly, in terms of the present study there has been even less emphasis placed on studying conditions that might facilitate self-disclosure or interpersonal trust, such as racially similar therapy dyads or groups with Mexican American participants and leaders. There is little utility in ascribing "therapeutic failures" to the personality traits of the minority client. Rather than *"blame the victim"* (Ryan, 1971) it would appear more profitable to experiment with approaches that lead to more efficient mental health care for all groups.

Phillipus (1971) tried to implement a group format that included both Anglos and Mexican Americans with varying degrees of English fluency. When English was the normative language, he observed high dropout rates for the Mexican American individuals. Those with little English mastery were immediately overwhelmed by the English format and dropped out quickly. However, even those Mexican American clients with greater English fluency also began to drop out. When interviewed, this group cited their inability to express themselves in English as the prime reason for termination. For example, one Mexican American man replied "We are not used to talking in groups. Often we feel that if we

say something it will not sound right—the words will not be the right order. We do not always know the right English words" (Phillipus, 1971).

In an attempt to reduce this dropout rate, Phillipus (1971) suggested that Spanish dialogue be allowed when necessary for getting a point across and that therapists and group members alike would assist in translations. The immediate result was the development of *two* group processes occurring at the same time, one conducted in English, the other in Spanish. Even the Anglo clients were at a loss as to what was occurring in spite of the fact that the exchanges were completely translated for them.

Prescriptive Psychotherapy

It becomes apparent that deciding how to structure a group with Spanish-speaking clients can be rather complicated. The option of creating exclusive bicultural groups conducted in Spanish could be viewed as potentially segregationist. However, one could accept the premise that all psychotherapy is essentially a *prescriptive* phenomenon (Magaro, 1969) where different types of patients benefit from different modalities of treatment. With this in mind, the present effort was directed toward increasing services to the target population characteristically receiving the least: the Spanish-speaking lower class.

The group format was chosen for two reasons: 1) it would allow for the treatment of a greater number of individuals, and 2) it would afford the experimental testing of multiple behavioral techniques within a group paradigm. Recent work by Goldstein (1973) has demonstrated the efficacy of highly structured behavioral approaches with low-income clients, hence the goal was to extend this model to treatment of low-income Mexican American clients.

Discussion of the Study

Group Composition

Considering that the group assembled for the study was the only Spanish-speaking psychotherapy group in existence at the clinic at the time, necessity demanded that the selection criteria be as non-exclusionary as possible. Consequently, all who were referred and who did not object to being in a group were accepted. It was predetermined then, by the nature of the study criteria, that no symptom profile could be projected for the group. This led to some initial apprehension about the success of the group when considering that a decision had been made to make the group a relatively didactic, goal-oriented, behavioral one. It seemed one thing to treat a group of agoraphobics, or a group of clients with

marital problems, or a group whose members were dealing with sexual dysfunctions, but it was quite another proposition to treat them in various combinations through use of a directive approach.

The literature did provide some insight into what one might expect in the way of problem areas. That is, studies on the Mexican American client have generally provided the perception that one would be dealing with women who were experiencing a great deal of depression, somatic disturbance, and marital concern (Fabrega, Rubel, & Wallace, 1967; Herman and Kahn, 1974; Normand, Iglesias and Payn, 1974). A number of similarities in problem areas were determined in the present client population; most of which seemed consistent with what the literature had reported. Table 1 presents that data, together with demographic information for group members. Summarizing the most significant findings: 1) 9 of 13 members were women; 2) 11 of 13 group members complained of significant somatic problems with 9 of the 13 indicating that this was the reason for referral; 3) 7 of 8 married members felt that significant problems existed in their marriage; 4) 8 of 13 members experienced depression to a great degree; 5) 10 of 13 members complained of anxiety; 6) 10 of 13 members exhibited significant sub-assertive styles; and 7) 6 of 9 members with children reported problems with them (2 of the 3 who did not report problems had children under the age of 5). One last finding of interest concerns the fact that although 8 of 13 group members had combined family incomes of less than $4,000 per year, only 1 of those 8 felt finances to be a major problem.

Treatment Strategy

As previously stated, several investigators have advocated that the treatment of low income clients (low income Spanish-speaking surnamed clients included) should attempt to employ a problem-oriented approach focusing both on present circumstances and design of active interventions as opposed to the traditional modalities emphasizing intrapersonal dynamics and insight (Garfield, 1971; Cohen, 1972; Reissman and Scheibner, 1965; Normand, Iglesias and Payn, 1974).

Numerous explanations exist for such findings. Some of the more well substantiated explanations suggest that such treatments are effective because they tend to be more consistent with the expectations that the low SES (Socio-Economic Status) client brings to psychotherapy. Lorion (1974) suggests that low SES clients often approach therapy with the expectation that the therapist should be active and that he provide advice helpful in the resolution of social or interpersonal issues rather than intrapersonal issues. Several other investigators have demonstrated similar results (Heine and Trossman, 1960; Cobb, 1972). Cobb's (1972)

TABLE 1

Group Composition

Demographic Data										Problem Areas R=reason for referral 1=primary 2=present									
Sex	Age	Marital Status	Nationality (1)	Legal Immigration Status	English Fluency (2)	Education in Years	Number of Children	Income (3)		Anxiety	Depression	Memory Loss	Somatic	Marital	Social Relationships	Children	Finances	Assertiveness	Substo
F	56	M	M	Yes	4	2	4	5		2	2	1R	1R	2	2	2	–	–	–
F	81	M	G	Yes	2	13	2	2		2	2	2	1R	1	–	1	–	1	–
F	29	M	ES	Yes	2	6	2	4*		2	–	–	1R	1	–	–	–	2	–
F	59	D	US	–	1	4	3	5		1	1R	–	2	–	2	2	2	1	–
F	26	M	US	–	1	12	4	2		1	2	–	1R	1	2	2	2	2	–
F	24	S	ES	No	4	6	–	4		2	1	–	1R	–	–	–	–	1	–
F	55	M	M	Yes	3	13	6	2		–	1	–	1R	2	2	2	2	1	–
F	45	M	M	Yes	4	2	11	3		–	–	–	1R	1	–	2	2	–	–
F	29	M	A	Yes	2	16	1	1*		2	1R	–	–	2	–	–	–	–	–
M	43	M	M	Yes	2	16	3	5		2	–	–	1R	–	–	–	–	2	–
M	29	D	M	No	4	6	2	4		2	–	–	1R	–	2	–	–	–	–
M	29	D	M	Yes	4	12	1	5		1R	2	–	2	–	1	–	–	2	–
M	17	S	M	No	4	10	–	5		1	–	–	–	–	1	1	1	2	1R

(1) M=Mexico
G=Guatemala
ES=El Salvador
US=United States
A=Argentina

(2) 1=Fluent
2=Moderate
3=Poor
4=No English

(3) 1=over $10,000
2=7-10,000
3=4-7,000
4=under 4,000
5=Welfare

*Both spouses working

review of low SES clients' orientation in therapy suggests that an individual who has the expectation that his problems will improve by "doing something" rather than by merely talking should be involved in an action oriented therapy which is exactly what the present study attempted to accomplish.

In order to meet the requirements of providing the group with a behavioral-problem oriented focus the initial task consisted of completing a behavioral analysis for each member. This was accomplished either during an individual session with one of the two therapists, or during one of the group meetings. This latter procedure was implemented since it proved advantageous in allowing all members to continue to learn and practice—both directly and vicariously—the delineation of workable goals (or "metas" as we referred to them in the group). Efforts were made to keep the goals as specific as possible. For example, as opposed to allowing the client to state a general goal such as: "I'd like my marriage to improve" the client was helped to make such statements as: "I want to have one night out on my own", or "I want to do the grocery shopping", "I want my husband to initiate love-making at least once during the week". Throughout the period of goal delineation and treatment, emphasis was placed on the fact that it was not necessary to change attitudes and feelings before behavior could change—indeed, the reverse could prove as effective if not more so.

Meeting once weekly, a typical group session lasted approximately an hour and a quarter. During that time, clients discussed the goal they were working toward. Homework assignments, if they had been given, were discussed, and new ones were negotiated. Difficulties were elucidated and other group members gave feedback and advice regarding all these issues. It was not infrequent that part of a session was taken up by a semi-didactic presentation on an issue which appeared to have relevance for the majority of the group. Determining what those issues were was a relatively straightforward matter once the behavioral analyses were completed. Guided by the data stemming from those behavioral analyses, one session was spent teaching all group members relaxation exercises (Bernstein and Borkovec, 1974). Two presentations on the finer points of behavioral contracting with marital problems were made (Weiss, Hyman, and Patterson, 1972) and one was conducted on behavioral contracting with children (Patterson, 1971).

Therapeutic Process Observations

Regarding intervention strategies, a number proved to be of exceptional utility. Beginning with the most general, the group setting itself

appeared to be an especially good vehicle for treatment with this particular client population. This observation is somewhat contrary to what one might expect given some of the data cited in the literature. That is, the literature generally tends to indicate: 1) the notion that Spanish-speaking clients are in general unreliable in the sense of motivation for attendance—using therapy as a crisis strategy only, and 2) that Spanish-speaking clients are exceedingly unwilling to self-disclose.

In general the "pitfalls" discussed in previous studies were not evidenced. The attendance rate ranged between 70 and 80%—not significantly worse, and perhaps even significantly better than attendance rates for non-Spanish speaking groups. Although the issue can only be addressed anecdotally, highly intimate issues were frequently discussed, ranging from a male member admitting to fear of physical confrontation to females discussing problems of a sexual nature.

Advantages inherent in the group setting were several, but two appeared to be of exceptional utility. The first had to do with the fact that group members were able to establish a larger support system than would have normally been possible in individual therapy. Social gatherings during the week were relatively frequent occurrences. This was especially salient in view of the fact that more than half the members indicated serious problems with social relationships prior to therapy. The second positive aspect of this technique stems from the increased tendency to therapeutically manipulate the tendency to somatize. It was noted that new members seemed able to quickly accept the notion that somatic concerns can frequently be mediated by anxiety and explained on the basis of emotional conflict. It was reasoned that this development occurred because members joining the group more recently experienced the benefit of learning from persons who not only had similar problems, but who had found assistance in looking at them from a psychological perspective.

Behavioral Analysis

The variable perhaps most important for the design of future treatment strategies concerns the use of behavioral analysis. This procedure was found to be particularly appropriate in that it prescribed in relatively straightforward fashion, the treatment required to initiate therapeutic change. In illustration of this point, a brief description of a number of the more specific intervention strategies utilized will be presented.

One of the problem clusters evidenced in the behavioral analysis had to do with difficulties in being assertive. This is not to say that great

consistency was found in the specific situations clients wished to improve but rather that there existed a common concern about assertiveness. For example, one client wanted to be able to tell her husband that she wanted to participate in vacation decisions. Another was unable to tell her medical doctors that she was unhappy with her treatment. Still another felt uncomfortable telling his brothers that he was tired of supporting them.

The finding of low assertives was not particularly surprising given the characteristic life circumstances of these particular clients. A number were or had been illegal aliens. This situation contributed to constant fear of deportation, and as a consequence rendered them relatively powerless in contact with governmental and social agencies. Secondly, the majority possessed a poor command of English, which undoubtedly contributed to their overall feelings of ineffectiveness in terms of personal interactions with the dominant culture. Finally, some felt the sting of overt discrimination and prejudice from the predominately Anglo population. Indeed, being assertive in such an environment would be a far more unexpected finding. Even more significant, however, was the finding that clients' behavioral deficiencies in this area were amenable to change using the standard armamentarium of assertion training: modeling, behavior rehearsal, etc.

An additional high frequency complaint was that of marital discord. The majority of reports were from women who not only felt that they wanted changes in their husband's behavior, but that the probability of getting their Macho man to change his behavior was minimal. In general the group discussions revealed that the traditional Mexican American marital relationship is undergoing considerable change. This role strain was evident in the women's demands for more power, greater freedom to engage in outside activity, and more personal attention from spouses. As mentioned previously, in keeping with the behavioral format of the present study, effort was directed toward translating global marital complaints to specific requests for partner change of behavior.

With numerous specific requests articulated, several sessions were spent [illegible]ining and role playing the use of marital contracting proce[illegible]he method was adopted readily and proved to be one of the mo[illegible]valuable skills developed by the clients. One woman who had previously decided to initiate divorce proceedings made a final attempt at reconciliation developing a set of behavioral prescriptions and contingencies for her and her spouse. Following several different levels of contracting they have managed to avert a divorce. Accompanying this relationship change, previous somatic complaints also began to diminish.

Curanderismo

A final observation involves the subject of curanderismo or folk medicine. When discussion shifted to this issue, the policy was *not* to challenge these beliefs but to allow for open discussion. While there was general awareness of the concepts of folk medicine, only one member had occasion to use a curandero. In addition, the overall majority indicated that they would not seriously consider using a curandero as a mental health resource. Nevertheless with such a diversity of opinions on the topic the best strategy seemed to be to encourage discussion. Without sanction from the therapists clients were allowed the freedom to acknowledge or reject the personal relevance of curanderismo.

Summary

In summary it is felt that the present observations demonstrate the utility of the group format as an effective therapeutic modality in working with low-income Spanish-speaking clients. The use of a structured-behavioral approach also proved to be successful in dealing with a wide variety of problems manifested by this particular population. This tends to be consistent with the research programs of both Goldstein (1973) and Sarason (1971) who argue for the use of highly structured, behavior-change oriented approaches to treatment of low SES patients. Furthermore, in addition to demonstrating the utility of class-linked psychotherapy, the attempt to make therapy culture-linked proved to be a significant component in the observed successes. It is suggested that greater effort be directed toward devising treatment plans that are tailored to the needs of target populations. Until this is done it would appear premature to claim that group therapy can not be successful when utilized with lower-class Mexican Americans.

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